Request for Information (RFI) #318.65-217 for Managed Care Organization (MCO) Serving Middle Tennessee Region

Issued by the State of Tennessee
Department of Finance and Administration
Bureau of TennCare

December 12, 2005

CENTENE®
Corporation

December 9, 2005

Alma Chilton, Contract Coordinator
Bureau of TennCare
310 Great Circle Rd
Nashville, TN 37243
(615) 507-6384
alma.chilton@state.tn.us

Re: Request for Information (RFI) #318.65-217 for Managed Care Organization (MCO) Serving Middle Tennessee Region

Dear Ms. Chilton,

Centene Corporation (Centene) is pleased to respond to the Request for Information (RFI) #318.65-217 for Managed Care Organization (MCO) Serving Middle Tennessee Region issued by the State of Tennessee, Department of Finance and Administration, Bureau of TennCare.

Centene's plans have provided Medicaid and CHIP physical and behavioral health plan programs to state Medicaid programs for over 20 years. Centene has health plans in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas, and Wisconsin, and we were recently awarded a contract to provide Medicaid and CHIP services in Georgia, which is scheduled to go live in April 2006. In addition, Cenpatico Behavioral Health, Centene's behavioral health subsidiary, provides behavioral health services in Arizona, California, Ohio, Indiana, Kansas, Missouri, Wisconsin, and Texas. In Arizona, California, Colorado, Indiana, New Jersey, Ohio, Texas, and Wisconsin, Centene provides also provides specialty services, such as NurseWise®, a 24/7 "in-house" nurse triage and education service; AirLogix, Inc., an industry leader in respiratory disease management; and ScriptAssist, an innovative, behaviorally based program that has achieved documented success in increasing compliance with prescribed medication regimens.

Centene understands that each state is unique, and we realize that the approaches that have been used by Centene plans in other states are not cookie cutter templates for what will be the best approach in Tennessee. However, our experience in other states can help us establish a starting point for understanding the dynamics in Tennessee.

We appreciate the opportunity to respond to the RFI and look forward to learning more about how Centene's programs can be developed and enhanced to meet the needs of TennCare enrollees and their families. If you have any questions regarding our response to the RFI, please contact me by telephone at 314-725-4477, ext. 25268 or through e-mail at dpaquin@centene.com.

Regards,

Daniel Paquin
Senior Vice President

Encl.

Table of Contents

Chapter 1. Corporate Background and Credentialing

1. Corporate Information

Name, Address, Telephone Number, Fax Number, Email Address

Daniel R. Paquin
Sr. Vice President, New Plan Implementation and Development
Centene Corporation
7711 Carondelet Ave., St. Louis, MO. 63105
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Email: dpaquin@centene.com

2. If a subsidiary or affiliate of a parent organization, corporate information of parent organization

Name, Address of Corporate Headquarters, Telephone Number, Fax Number, Email Address

Not applicable, as Centene Corporation (Centene) is the parent company and the corporate headquarters.

3. State of incorporation or where otherwise organized to do business

Centene Corporation is incorporated in Delaware. We have subsidiary organizations that are licensed and do business in the following states: Arizona (behavioral health only), Indiana, Kansas, Missouri, New Jersey, Ohio, Texas, and Wisconsin. In July 2005, one of our subsidiary organizations, Peach State Health Plan, was awarded a contract to do business in the state of Georgia, which will go live April, 2006.

4. States where currently licensed to accept risk and a description of each license

The following table lists the states where Centene companies are licensed to accept risk and a description of each license.

Table #1: States where Centene Companies are Licensed to Accept Risk

Company name	Type of license	State	License number
Centene Management Company LLC	Third Party Administrator	TX	94667
Centene Management Company LLC	Third Party Administrator	MO	TP8019596
Centene Management Company LLC	Third Party Administrator	OH	30417
Centene Management Company LLC	Utilization Review	MO	UR8019596
Cenpatico Behavioral Health LLC	Third Party Administrator	TX	31-095675
Cenpatico Behavioral Health LLC	Third Party Administrator	KS	902163
Cenpatico Behavioral Health LLC	Third Party Administrator	OH	30539

Company name	Type of license	State	License number
Cenpatico Behavioral Health LLC	Utilization Review	IN	34525
Cenpatico Behavioral Health LLC	Utilization Review	MO	UR8020335
Desert Springs Professionals LLC (a subsidiary of Cenpatico Behavioral Health, LLC)	Behavioral Health License	AZ	BH2252
Desert Springs Professionals LLC (a subsidiary of Cenpatico Behavioral Health, LLC)	Outpatient Clinic - counseling	AZ	BH2511
Integrated Managed Health Services, Inc. (a subsidiary of Cenpatico Behavioral Health, LLC)	Third Party Administrator	TX	13065
Integrated Managed Health Services, Inc. (a subsidiary of Cenpatico Behavioral Health, LLC)	Utilization Review	TX	URA04818
Cenpatico Behavioral Health of Texas, Inc. (a subsidiary of Cenpatico Behavioral Health, LLC)	HMO specialty license	TX	pending
Superior HealthPlan Inc.	HMO	TX	94703
Coordinated Care Corporation Indiana Inc. (d/b/a MHS Indiana Inc.)	HMO	IN	95831
Buckeye Community Health Plan, Inc.	Health Insuring Corporation License	OH	11834
Managed Health Services, Inc. (Wisconsin)	HMO	WI	
University Health Plans, Inc.	HMO	NJ	
FirstGuard Health Plan, Inc.	HMO	KS	95364
FirstGuard Health Plan, Inc.	HMO	MO	D 1001040
FirstGuard Health Plan Kansas, Inc.	HMO	KS	95620
Peach State Health Plan, Inc.	HMO	GA	
NurseWise LP	Outpatient Clinic	AZ	BH-2636
Academic Behavioral Alternatives (a subsidiary of Cenpatico Behavioral Health, LLC)	AZ Dept. of Education	AZ	07-21-96-000

5. Contact Information

Name, Title, Telephone Number, Fax Number, Email Address

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6. Program Experience – General

Given TennCare's history with small, inexperienced plans becoming insolvent, the State is interested in contracting with MCOs that have substantial experience with capitation, particularly for the Medicaid population.

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

Yes, we have more than three years Medicaid experience under capitation. The following table lists the Medicaid MCO contracts currently held by Centene-owned health plans in which our plans are providing services under capitation; as well as the name of the Centene subsidiary company under which we do business in that state; and the contract start date and duration.

Table #2: Capitated Medicaid MCO Contracts Held by Centene Owned Companies

State of operation	Centene-owned health plan providing Medicaid services under capitation	Contract start date and duration
Arizona (behavioral health services only)	Cenpatico Behavioral Health of Arizona LLC[1]	Awarded March, 2005 Went live July 2005
Indiana	Coordinated Care Corporation Indiana, Inc. (d/b/a Managed Health Services)	Has held contracts since 1993; expansion awarded January 1, 2005
Kansas	FirstGuard Health Plan Kansas, Inc.	Has held the current contract since 1999
Missouri	FirstGuard Health Plan, Inc.	Has held the current contract since 1997
New Jersey	University Health Plans, Inc.	Has held the current contract since 1994
Ohio	Buckeye Community Health Plan, Inc.	Has held contract since January 1, 2004; contract expansion in 2005
Texas	Superior HealthPlan, Inc.	Has held contracts since 1999; has had numerous expansions awarded
Texas	Bankers Reserve Life Insurance Company of Wisconsin (d.b.a. Superior HealthPlan Network)	September 1, 2004 to August 31, 2007
Wisconsin	Managed Health Services Insurance Corporation (MHS)	Has held contracts with the State of Wisconsin for 20 years; has had numerous expansions awarded
Wisconsin	Managed Health Services Insurance Corporation (MHS)	January 1, 2001 to December 31, 2011

b) Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

Neither Centene Corporation nor any of its subsidiary health plans are currently accredited by NCQA; however, we are currently in the early stages of preparing to become accredited. In addition, one of our subsidiaries, Cenpatico Behavioral Health, is currently accredited by URAC.

[1] A subsidiary of Cenpatico Behavioral Health LLC.

Should we be awarded a contract in Tennessee, we would be pleased to become NCQA accredited within a reasonable period of time following contract award. This is also a condition of the contract that we have been awarded in Georgia.

Currently, Centene health plans conduct HEDIS reporting in Indiana, Kansas, Missouri, New Jersey and Ohio. This includes conducting the CAHPS survey in Indiana, Kansas, and Missouri. In all other states where Centene's health plans operate, the CAHPS survey is conducted by the State on our behalf.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

Yes, please see below.

7. Medicaid Program Experience – Services

Using the list below, please provide a chart that indicates for each of the states where you currently contract:

1) Whether you provide the service; and

2) Whether you provide the service directly or through a subcontract arrangement.

Table #3 lists the states where we currently contract, the services that we provide in each state and whether we provide that service directly or through a subcontract arrangement.

Table #3 - Medicaid Program Experience – Services

Type of Service Provided	Arizona	Indiana	Kansas	Missouri	New Jersey	Ohio	Texas	Wisconsin
a. Physical Health Benefits	No	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly
b. Dental Benefits	No	Yes, for medically necessary dental services provided outside a dentist's office	No	Yes, subcontract with Doral Dental	Yes, subcontract with Doral Dental	Yes, subcontract with Doral Dental	No	Yes, subcontract with Southeast Dental Associates
c. Vision Benefits	No	Yes, benefit limits exist	Yes	Yes, subcontract with VSP	Yes, subcontract with Davis Vision	Yes, subcontract with Davis Vision	Yes, subcontract with Total Vision Health Plan	Yes, subcontract with Herslof's, Inc.
d. Non-Emergency Transportation	Yes	Yes, subcontract with LCP Transportation, LLC TANF only	Yes	Yes, subcontract with Swope Transpor-tation	Yes, higher mode transportation through network of participating providers	Yes, subcontract with Diversified Transportation	Provided by State; however, plan has some individual agreements in instances where State cannot	Yes, subcontract with multiple vendors
e. Behavioral Health Benefits	Yes, provided directly[2]	Yes, provided directly[3] Inpatient and Rx	For Title XXI - provided directly[3] State adminis-ters Title XIX	Yes, provided directly[3]	No, BH is carved out in NJ, with the exception of the Division of Developmental Disabilities (DDD), a subset of the SSI population, for whom services are provided directly by UHP	Yes, provided directly[3]	Yes, provided directly[3]	Yes, provided directly[3]

[2] Services provided by Cenpatico Behavioral Health of Arizona, LLC
[3] Services provided by Cenpatico Behavioral Health, LLC

Type of Service Provided	Arizona	Indiana	Kansas	Missouri	New Jersey	Ohio	Texas	Wisconsin
f. Pharmacy Benefits	Yes, fully capitated services delivered through subcontract with Caremark/PCS	Yes, through subcontract agreements with ScripSolutions and Caremark, Inc. No OTC for SCHIP except insulin	Yes, subcontract with Express Scripts	Yes, subcontract with Express Scripts	Yes, through subcontract agreements with ScripSolutions and Caremark, Inc.	Yes, subcontract with ScripSolutions & Caremark, Inc.	No, benefit remains with State	Yes, subcontract with ScripSolutions & Caremark, Inc.
g. Long-Term Care Benefits	No	Yes, up to 90 days for SCHIP only	No	No	No	No	No	No
h. Home Health	In home behavioral health and support services	Yes, benefit limits	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly
i. Claims Processing and Adjudication	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly
j. Quality Assurance	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly
k. Utilization Management	Yes, inpatient care prior authorized; other services managed by contract	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly
l. Case Management	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly

Type of Service Provided	Arizona	Indiana	Kansas	Missouri	New Jersey	Ohio	Texas	Wisconsin
m. Disease Management	Yes, mental health issues, schizophrenia, bipolar disorder, major depression, and co-occurring mental illness/substance abuse	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly
n. Provider Credentialing	Yes, primary source verification completed through subcontract with Greater Arizona Central Credentialing Program (GACC)	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, although some large provider groups have Delegation Agreements	Yes, provided directly; also hold a number of delegated agreements with provider systems
o. Enrollment Assistance	Yes, provided directly	No	No	No	Limited contractual activity, provided directly	No	Not Medicaid; SCHIP only	No.
p. Member Services (inquiry, ID cards)	Member Services provided directly. No ID cards.	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly
q. Member Grievances/ Appeals	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly	Yes, provided directly

8. Medicaid Program Experience - Population

Using the list below, please submit a chart that includes for each of the states where you currently contract:

1) The population(s) served

2) The approximate number of individuals served in each population

Table #4 lists the states where we currently contract, the total population served in each state and the types of populations served in each state. Please note that Centene is a publicly-owned company, and, as such, we cannot disclose specific membership breakdowns that exceed the information publicly available in our quarterly releases.

Table #4 - Medicaid Program Experience – Population

	Arizona	Indiana	Kansas	Missouri	New Jersey	Ohio	Texas	Wisconsin
Population Served	Behavioral health recipients – TANF, SCHIP and low-income uninsured	TANF & SCHIP	TANF & SCHIP	TANF & SCHIP	TANF, ABD, DYFS, SCHIP & low-income uninsured	TANF & SCHIP	TANF, SCHIP & SSI	TANF, SOBRA, SCHIP & SSI
Total Population (as of Sept. 30, 2005)	94,000	176,300	107,600	37,300	50,900	58,100	243,800	173,900
Aged, Blind and Disabled – excluding dual eligibles	No	No	No	No	Yes	No	Yes, Voluntary	Yes
Dual Eligibles: individuals eligible for both Medicaid and Medicare	No	No	No	No	Yes	No	No	Yes
TANF and TANF-Related	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SCHIP	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Waiver Expansion Population (low-income uninsured)	Yes	No	Yes	Yes	Yes , NJ FamilyCare program	No	No	Yes, parents of SCHIP children
SPMI (Seriously and Persistently Mentally Ill)	Yes	No	No	No	Yes, if the individual qualifies for Medicaid/Family Care and is in the community	Yes, if Medicaid eligibility falls under Healthy Start/Health Families	Yes	Yes
SED (Seriously Emotionally Disturbed Children/Youth)	Yes	No	No	No	Yes, if the individual qualifies for Medicaid/Family Care and is in the community	Yes, if Medicaid eligibility falls under Healthy Start/Health Families	Yes	Yes

8. Medicaid Program Experience - Population (cont.)

The following table provides a breakdown of our membership by line of business as of Sept. 30, 2005.

Table #5: Membership by line of Business

Type of Population	Membership as of Sept. 30, 2005
Medicaid	657,500
SCHIP	176,900
SSI	13,300
Total	**847,700**

9. Medicaid Program Experience – Payment Methodology

Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

The payment methodology for all of the state contracts listed in the table above is full-risk capitation. Pharmacy is carved out in Texas, and for the SSI population in New Jersey.

Currently, Centene does not participate in any financial incentives with the states to whom we provide services.

10. Experience – Former Medicaid and/or Commercial

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

Not applicable.

Chapter 2. Reformed Managed Care Model

A. Behavioral Health

1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

Centene currently provides behavioral health services in seven states through our subsidiary companies, Cenpatico Behavioral Health, LLC (CBH) and Cenpatico Behavioral Health of Arizona, LLC, which is a subsidiary of CBH. The states where we currently provide behavioral health services to Medicaid recipients are: Arizona, Indiana, Kansas, Missouri, Ohio, Texas, and Wisconsin. In April, 2006, CBH will begin providing behavioral health services in Georgia.

In all of these states, there are individuals with serious emotional disturbance (SED) and severe persistent mental illness (SPMI) to whom CBH directly provides behavioral health services. However, in Arizona, Texas and Wisconsin, these populations are specifically defined, and our programs are targeted for these individuals.

In Indiana, Kansas, Missouri, Ohio, Texas, and Wisconsin, member/provider services and complaints/grievances and appeals are handled through CBH's headquarters in Austin, Texas. Claims processing is handled through Centene Corporation's Claims Service Center (CSC) in Farmington, Missouri.

In Arizona, member/provider services and complaints/grievances and appeals are handled through Cenpatico Behavioral Health of Arizona, LLC. Claims processing is handled through Centene Corporation's Claims Service Center (CSC) in Farmington, Missouri.

The following table details the states where CBH companies provide services, as well as the population served in each state and the types of services provided.

Table #6 – Behavioral Health Services

Contract Venue	Population Served	Type of Service Provided
Arizona	TANF, SCHIP, low-income uninsured Medicaid-enrolled special education students and youths at-risk for out-of-home placement	To TANF, SCHIP and low-income uninsured: Full continuum of Behavioral Health Care services To Medicaid-enrolled special education students: specialized school-based program for children with behavioral conditions, community-based after-school, Saturday and summer social and recreational programming
Indiana	Title XIX, Medicaid, SSI & SCHIP	Inpatient UM
Kansas	SCHIP	Full continuum of Behavioral Health Care services
Missouri	Medicaid Child Health+	Full continuum of Behavioral Health Care services
Ohio	Healthy Family, Healthy Start	Inpatient & "exception" outpatient services (when not available through Community Mental Health Centers)
Texas	Title XIX, Medicaid & SSI Medicaid SCHIP enrollees	Full continuum of Behavioral Health Care services

Contract Venue	Population Served	Type of Service Provided
Wisconsin	Title XIX, Medicaid & SCHIP enrollees	Inpatient & Outpatient Services

2. Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.

Centene has developed an innovative approach to health care that is promoted throughout our health plans. The Centene approach is based on the following key principles:

- The integration of physical health and behavioral health
- A focus on preventive health
- A community-based approach to care management and advocacy
- A physician-driven approach to health care

We view the integration of physical health and behavioral health as a vital component to ensuring successful care coordination and service integration.

Centene's health plans provide extensive training and support to providers to ensure that physical health providers are able to identify and appropriately refer enrollees who need Behavioral Health (BH) care, and that BH Providers are able to do the same for enrollees needing physical health care. Effort is invested to ensure that both types of providers are well-versed in coordination protocols, including how to work with CBH Care Managers and Health Plan Care Coordinators, to facilitate coordination of services for the enrollee across the full continuum of care. Centene's approach also takes physical and behavioral health care integration to the next level, through an integrated information system -- McKesson's CareEnhance Clinical Management Software (CCMS) -- which allows documentation and retrieval of all care that an enrollee receives, regardless of its source. This integrated, state-of-the-art system enables Centene's health plans to examine both BH and physical health encounters for each enrollee and to better direct the enrollee toward a healthy outcome.

Care Coordination and Service Integration between Behavioral Health Providers and Physical Health Providers

As mentioned above, effective service coordination and integration relies on integrated data between the health plan and the behavioral health organization. All of Centene's health plans and CBH operate on the same clinical software platforms. These integrated systems facilitate the HIPAA compliant exchange of information between the health plan and the behavioral health organization. For example, the name and address of the enrollee's PCP is readily available to CBH Customer Service staff when they are making referrals, allowing them to pass that information to the behavioral health provider, so that he/she can coordinate care with the PCP. In many cases, Centene and CBH also co-locate Case Management and Provider Relations staff in the same office, so that they can better coordinate services for enrollees in need.

Centene and CBH have extensive knowledge in care coordination and service integration between behavioral health and physical health providers. Both companies recognize that communication is the link that unites all the service components and is a key element in any program's success. To further this objective, CBH requires its providers to obtain consent for disclosure of information from the enrollee, thus permitting exchange of clinical information between the behavioral health provider and the enrollee's physical health provider. By contract, behavioral health practitioners are expected to communicate with PCPs whenever there is a behavioral health problem or a treatment plan that can affect an enrollee's medical condition or the treatment being rendered by the PCP. Likewise, Centene health plans encourage their PCPs to coordinate with behavioral health providers when there is overlap in their treatment of an enrollee.

Situations in which coordination is expected to occur include:

- Whenever a medical provider prescribes medication for a behavioral health problem or diagnosis
- Whenever an enrollee is known to abuse over-the-counter, prescription, or illegal substances in a manner that can adversely affect medical treatment
- Whenever an enrollee is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder

Centene and CBH provide extensive education to providers about the need to and benefits of coordinating care between the physical health and behavioral health providers. This education is delivered using the following strategies:

- Provider manual documents
- Provider seminars and training sessions
- Provider newsletters and written information
- Personal contacts between Centene and CBH personnel
- Information and links on both the Centene and CBH websites
- Integrated service programs developed between Centene health plans and CBH

In Wisconsin, for example, Centene operates a unique Care Coordination program for individuals with SPMI and other exceptional needs. Health plan and CBH clinical and care management staff are co-located at the Centene health plan in a "Pod" arrangement. These staff members form an inter-disciplinary team that coordinates services, referrals, and authorizations across the continuum of care, in order to meet the entire scope of enrollees' treatment requirements. This program is considered a "best practice" with regard to the provision of integrated physical and behavioral health care services. The integrated pod model permits a level of collaboration that is not possible in an environment in which the physical and behavioral aspects of an individual's care are managed by physically separated Care Managers working in separate organizations. Centene's integrated approach is enhanced by a common management information system, which is available to both physical health and behavioral health Care Management staff, and which includes: up-to-date enrollee information; provider information; results of physical health, behavioral health and other assessments; current physical health and behavioral health issues or goals; and information that allows the treatment team to monitor enrollees' overall health outcomes.

CBH staff, including Customer Service Representatives, Care Managers, Care Coordinators, and Provider Relations staff, receive orientation to and continuing education about the physical health benefits available to enrollees. This training includes information on the various health plans and their referral and contact information. CBH staff are instructed on how to refer cases to the physical health plan or to specific providers, such as PCPs, so that they can advise behavioral health providers who call seeking assistance.

CBH network practitioners are encouraged to be accessible to PCPs and other medical providers, to discuss behavioral health issues that may arise related to enrollees being seen for both behavioral health and physical health problems. In many cases, the PCP has extensive knowledge about the enrollee's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is emphasized. Care Managers also elicit relevant medical history as part of their initial assessment when enrollees seek outpatient behavioral health care. Information regarding medical problems or treatment that can affect or be affected by behavioral health problems is communicated to the behavioral health practitioner at the time of referral.

Experience with Ethnically and Racially Diverse Populations in Physical Health and Behavioral Health Settings

Centene and CBH are committed to facilitating service access to all enrollees – including ethnically and racially diverse populations, as well as others with limited English proficiency, limited reading skills, and physical disabilities – and to ensuring that all enrollees know how to properly access, and are comfortable accessing, needed health care services.

It is to that end that we:

- Notify all Enrollees regarding the availability of materials in alternative languages and formats
- Provide call center services and written materials in various alternative languages and formats
- Recruit providers who are experienced at providing services to people with limited English proficiency, limited reading skills, and physical disabilities, and indicate who these providers are, so that Enrollees can be properly referred to them
- Train all of our providers to be sensitive to the needs of Enrollees who require special services
- Provide specialized services to Enrollees, such as interpreter services and transportation services
- Constantly monitor our network and solicit feedback, to ensure that Enrollees with limited English proficiency, limited reading skills, and physical disabilities are successfully able to access services
- Have installed computer kiosks with training assistance in health centers in Georgia, in order to educate Medicaid recipients about preventative health care and the changes in Georgia's Medicaid program

Notifying Enrollees of the Availability of Materials in Alternative Languages and Formats

Written notification: The front page of all written materials, including marketing and enrollment materials, that are distributed to enrollees or the public, and that are posted on the Website, include notice of the availability of, and how to request, materials in alternative formats, as well as written or oral translation, and help in understanding materials.

Verbal notification: In all of our markets, enrollees receive phone line services from NurseWise LP, a wholly-owned subsidiary of Centene that provides nurse triage and education services to enrollees on a 24/7 basis. NurseWise staff also attempt to make outreach calls to new enrollees in many of our markets. During the Welcome Call and also in subsequent contacts with Customer Service representatives, enrollees are notified that they may receive written materials in alternative languages and formats.

Call Center Services for Enrollees with Limited English Proficiency

Both Centene and CBH strive to employ Customer Services Representatives and other staff members who are bi-lingual in English and Spanish. Additionally, 95% of the staff at NurseWise are bi-lingual in English and Spanish. CBH also recognizes that there are other languages spoken by significant percentages of our enrollees, and where warranted, we seek to employ staff who mirror the populations we serve.

Following are a few examples of how Centene companies meet the special needs of our enrollees:

- Because Centene's Wisconsin Customer Service Representatives speak so many of the languages spoken by the enrollees (English, Spanish, Russian, Hmong, Vietnamese and Laotian), the plan has only needed external Language Line services once in two and a half years. Additionally, most of the materials distributed to Centene Wisconsin enrollees and posted on the Website are available in English, Spanish, Russian and Hmong.
- At Superior HealthPlan in Texas, all of the Customer Service Representatives are fluent in both English and Spanish.
- At CBH Arizona, the Enrollee section of the Website is available in both English and Spanish
- In all of our markets, when developing educational and outreach strategies for specific sub-groups in the area, we rely heavily on the coalitions we build with local groups that are familiar with the service area's population. For example, Northern Indiana has recently experienced a growing number of immigrants from Africa. As a result, the Centene plan in Indiana has recruited a diverse provider community that mirrors our enrollees; these doctors have been able to lend their expertise in communicating and outreaching to Somalis and Nigerians for whom English is not a primary language.

Centene and CBH ensure that all of our translated written materials are certified by professional interpreters or translation services. Additionally, all new staff are evaluated for fluency, understanding of our populations' cultural characteristics, and knowledge of health care terminology, before they are allowed to provide interpreter/translation services.

Use of Language Line Services

When a caller's request is for a language not available among Centene company staff, then we make use of commercially available translation/interpreter services, such as the Language Line Services, which provides translation for 161 languages.

Availability of TDD Equipment

All Centene, CBH and NurseWise Call Centers are with staff who are trained to use telephonic translation equipment for the hearing impaired. This equipment is available 24 hours a day, 7 days a week. All Centene companies comply with Title III of the Americans with Disabilities Act (ADA).

Written Materials for Enrollees with Limited Reading Proficiency

Centene and CBH develop easy-to-read materials that meet all applicable state and federal requirements. All marketing and enrollment materials are developed at or below a 4th through 6th grade reading comprehension level, as measured by the Flesch-Kincaid Readability program, and adhere to the Centene-wide standards for ensuring that materials are accessible to enrollees with limited reading proficiency. Such standards include use of a friendly tone, active voice, common words, short sentences, etc. We also obtain enrollee feedback to ensure a clear message and cultural appropriateness

Facilitating Service to Ethnic and Racially Diverse Enrollees

Centene and CBH Provider Directories indicate the languages spoken by each provider. Centene is currently implementing an automated look-up function via the Web that will enable enrollees, Care Coordinators and Customer Service staff to enter the enrollee's zip code and to find providers located near the enrollee who speak the Enrollee's preferred language and best meet the enrollee's needs. This automated look-up function is presently in use at CBH Arizona.

Interpreter Services

While it is always preferable to find a provider who can provide treatment services in the native language of the enrollee, this is not always possible. In those cases where an interpreter is required, the Care Coordinator assists in locating an interpreter to accompany the enrollee to his/her appointment, and the Centene health plan pays for the interpreter's services during the visit. Oral interpretation services for all non-English services are provided to enrollees free of charge, and Centene and CBH companies maintain a list of interpreters who are "on-call" to provide interpreter services. Family members or friends are not used as interpreters in behavioral health treatment.

Centene and CBH provide 24-hour access to interpreter services for enrollees, in order to facilitate access to emergency medical and behavioral health services within our networks.

Monitoring the Provider Network

Centene and CBH companies conduct regular monitoring of our networks, in order to ensure that enrollees with limited English proficiency, limited reading skills, and physical disabilities are able to access services. Analyses of how well we are meeting Enrollees' needs are based on the following:

- Monthly provider access reports
- Reviews of enrollee complaints
- Feedback received from our Community Advisory Councils, our Consumer and Family Advisory Councils and other community advocates, regarding gaps that may exist in the network and that may hinder access to Enrollees with limited English proficiency, limited reading skills, or physical disabilities.

Our Network Management and Quality Improvement Departments work together to conduct these analyses, and to identify opportunities for improvement, which may include expanding the network and/or conducting additional training for providers.

3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with SED and SPMI.

a. Please describe your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).

CBH has extensive experience engaging underserved and hard to reach populations. In Arizona, Texas, and Wisconsin, where SED and SPMI are defined populations that we serve, CBH works closely with providers to design, implement and continuously improve specific programs for the SED and SPMI populations. For example, in Arizona the CBH program includes early intervention through active community-based outreach programs. The outreach programs also coordinate with school systems and other community agencies in the early identification of individuals who are in need of behavioral health services, and with provider agencies, to ensure that there are adequate rehabilitation services to address. The Arizona model is based on recovery principles, with an emphasis on enrollee engagement and "voice and choice."

In Texas and Wisconsin, CBH has experienced particular success with SED and SPMI populations, by using proactive outreach methods, and by seeking to obtain the information needed to identify enrollees who may be in need of increased services and supports. Some of the strategies that CBH uses to identify enrollees with SED and SPMI include:

- Developing letters of agreement with health plans and other agencies, to design and implement outreach and screening programs for those with chronic medical conditions or other significant risk factors for behavioral health problems
- Assisting indigent individuals who seek services and ensuring that they are assessed for potential disability applications, and that all possible avenues are pursued to obtain eligibility status
- Making outreach calls to all new enrollees and conducting initial screenings, which can identify historical utilization of service as well as risk factors
- Monitoring provider efforts to re-engage enrollees who withdraw from the treatment process, refuse services, fail to appear for appointments, or experience a crisis or level of care transition
- Collaborating with state and advocacy groups, such as National Association for Mental Illness (NAMI), to ensure that information is distributed and outreach efforts are supported

In addition to outreaching to enrollees with SED and SPMI, CBH partners with significant provider groups and community agencies, in order to implement focused activities that engage and retain such enrollees in care.

b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

We believe that services to and for SED and SPMI populations are an integral part of any health plan design. These populations should be included in any program population, in order to ensure continuity of care and full access to services, and to prevent cost-shifting between different programs with different funding streams. Statistical models can identify the numbers of these individuals that programs would be expected to identify and serve, and programs should be monitored by state oversight agencies to ensure that enrollees are being properly identified, placed, and served.

Program components should include a proactive outreach approach, in order to actively identify potential cases. Individuals accessing care should have comprehensive treatment and crisis plans developed and kept available to program providers on a 24/7 basis, as is done by Centene and CBH programs. This ensures that enrollees receive the best possible intervention during times of crisis and/or decompensation.

The service provider network should include services at all levels. Benefits should not be limited by plan design; rather, they should be controlled by care management.

c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?

Centene and CBH's interest in this contract would be negatively impacted if the SED and SPMI populations were excluded. As noted above, we believe that a fragmented delivery system results in a poorer care system for enrollees, as well as potential cost-shifting between programs and negative outcomes for the enrollees. Centene supports an integrated delivery model, in order to increase the quality and efficacy of health care delivery.

d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

While Centene would prefer that these populations be rolled into a single funding stream and that the mechanism be a full-risk contract, Centene would consider a limited risk or no risk arrangement for these populations, as long as Centene was in the position of controlling the programming, utilization, and payments for these enrollees. The service delivery system to our providers would then remain seamless, and they would not notice, nor would they be aware of, any difference in funding streams. Internal Centene and CBH staff would also not see any difference in funding streams, and could therefore focus on effective care management, rather than the management of different funding streams.

4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.

Centene's health plans understand that we need to reach our enrollees in the neighborhoods where they live and work, and we must create a presence in the places they frequent. As a result, we place a high emphasis on establishing relationships with essential community providers, such as Significant Traditional Providers (STPs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs), who demonstrate their commitment to the underserved population. Centene's plans have expertise in providing the special support that STPs, RHCs, FQHCs, and CMHCs typically need, both initially, when shifting from fee-for-service to managed care, and later, usually due to the less commercial nature of their practice (for example, switching from paper to electronic claims submission). This has also included providing key STPs with computer kiosks, so that enrollees can access online health care information.

In accordance with this philosophy, Centene has begun establishing relationships with essential community providers in Tennessee. Likewise, in Georgia, Centene invested over two years prior to contract award, in meeting with essential community providers and in working with them to develop strategies to prepare them to provide quality care within a managed care environment.

Presently, Centene's health plans in seven states contract with 57 FQHCs, which represents more than 80% of the FQHCs in the service areas where they operate, and 100% of the FQHCs in Ohio, Texas, and Kansas City. Moreover, the network Centene has developed in Georgia, in anticipation of our projected start date for service delivery in April, 2006, includes 100% of the FQHCs in Georgia.

Not only are STPs included in Centene plan networks, Centene plans also include STPs in our health plan governance at the highest level of the Board of Directors, as well as throughout health plan committees and initiatives. The cornerstone of Centene's STP approach is our longtime alliance with FQHCs (also called community health centers, which are STPs).[4] For example, Jose Camacho, the Board Chair of Centene's Texas health plan, is the Executive Director of the Texas Association of Community Health Centers. FirstGuard, a Kansas and Missouri health plan acquired by Centene in 2004, began as an FQHC. In addition, two Georgia FQHC executives are included on the Board of Directors of Centene's Georgia-based health plan; Dr. Michael Brooks, who is the Executive Vice President at West End Health Center in Atlanta, and Dr. David Williams, who is the CEO of Southside Medical Center, also in Atlanta.

[4] By federal law, FQHCs were designed to provide care in underserved communities, and a large proportion of their patients are Medicaid clients. FQHCs are highly organized, as exemplified by the National Association of Community Health Centers and the affiliated Georgia Association for Primary Health Care.

In addition to FQHCs' involvement in health plan policy through the Board of Directors, and operational decisions through regional STP and FQHC representation, such as on the Utilization Management and Credentialing Committees, FQHCs have benefited from Centene's commitment to strengthening and expanding FQHC capacity and services. For example, in Texas, FQHCs have joined our behavioral health network, in order to provide co-located behavioral health and physical health services and to test specific interventions to improve integration of such services.

Following are several examples of Centene's collaborative experience with essential community providers in various states:

- In Georgia, as previously mentioned, the Centene health plan collaborates with Georgia FQHCs and seeks their involvement in planning and conducting community Town Hall Meetings that provide important feedback to the health plan. Such meetings have included representatives from more than 20 organizations, including Georgia public health departments, private providers, physicians, Head Start, and others.
- In Indiana, Centene's health plan was named the 2003 "Health Care Champion of the Year" by the Indiana Minority Health Care Coalition, in recognition of the plan's extensive involvement with community service providers and advocates, such as Wheeler Boys and Girls Club, local minority health coalitions and community action agencies, Covering Kids and Families, March of Dimes, the Urban League, the Domestic Violence Network of Greater Indianapolis, and the United Way.
- In Kansas, CBH partners with CMHCs to develop and implement innovative community treatment options and community based services.

5. Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?

Our experience is that a clearly defined benefit package that meets the needs of enrollees is critical to the success of a program. We support models that provide actuarially sound financing for benefit packages. Adequately funded behavioral health programs have a positive impact in reducing overall medical costs.

In addition, Centene believes that carving pharmacy services out of physical health, behavioral health, and SSI managed care programs will undermine the efficiency and soundness of approach to pharmacy services in the State's managed Medicaid population and will also have a detrimental impact on overall patient care.

Centene believes that quality of care and financial efficiency are best accomplished by integrating pharmacy into the care management system. The overriding concern in managing health care delivery systems is to ensure high quality care, while also promoting appropriate costs. Centene feels this goal is best achieved by fully integrating the pharmacy program into a comprehensive care management program. Although a separate, carved out, Pharmacy Benefit Management (PBM) system may achieve some savings in Fee-For-Service (FFS), far greater impact and better health outcomes are realized by having plan pharmacists working onsite with the CMOs, care managers, hospitals, physicians, and local pharmacies.

B. Pharmacy Services

1. Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.

Two of the leading causes of increasing pharmacy expenditure are poly-pharmacy issues and the inappropriate use of pharmaceuticals. Following are two examples of pharmaceutical programs that we recommend, which address poly-pharmacy and quality issues:

- **Medicaid enrollees who receive two or more medications in the same therapeutic class.** It is Centene's experience that the two therapeutic classes in which this commonly occurs are mental health

medications and narcotic pain medications. We recommend that enrollees be identified by using the pharmacy data (referred in question 2) and that an outreach communication be made to the prescriber and/or the enrollee, so that the enrollees can be placed in the appropriate case management program.

- **Asthma.** We recommend that the pharmacy data be queried to look for enrollees using three or more short-acting beta-agonists in six months, or who are receiving short-acting beta-agonists on a routine basis, but are not receiving a controller medication, as outlined by the current National Institutes of Health Asthma Treatment guidelines. The Primary Care Physician (PCP) of the identified enrollees would then be contacted regarding the findings of the asthma query, to ensure that the enrollees are being compliant with the prescribed treatment regimen, and that the enrollees are placed in the asthma case management program for proper follow-up.

These examples of pharmaceutical monitoring programs will lower the total healthcare expenditure (though not necessarily the pharmacy expense), and, more importantly, will promote the proper utilization of pharmaceuticals. Lower healthcare costs will be achieved due to less utilization of emergency visits and hospitalizations.

Experience with Situations in which a Pharmacy Carve-Out Exists

Centene has limited experience collaborating with a state-contracted PBM in an environment where a pharmacy carve-out exists. In Texas, where a pharmacy carve-out is mandated by the State, we receive pharmacy paid claims data that we then integrate with medical claims data for analysis. After the data is received, there is no further communication and information exchange with the State PBM.

In Tennessee, in order to foster collaboration between the MCO and First Health (TennCares' PBM), we recommend that First Health provide the MCOs with basic monthly reports that identify high utilizers of pharmacy services, high prescribing providers and enrollees suspected of fraud and abuse. As part of our standard UM and Care Management process, these enrollees would then be referred to Case Management for a thorough review of their medical and pharmacy treatment plans, to ensure appropriateness, while the providers could be referred back to the PBM and to our Provider Services department. We would expect to see collaboration between the PBM and the MCO, with State oversight, in dealing with pharmacies, prescribers and enrollees.

In addition, Centene is currently involved in "Appropriate Antibiotic Usage" programs in all of our regional health plans, and we could easily include First Health as part of the program team. We believe that First Health would share our goal of encouraging the Medicaid population to use antibiotics appropriately. Timely pharmacy data supplied to us by First Health, or access to real time pharmacy data via the Internet, would be very helpful in tracking enrollees' medication compliance and adherence. If this data were required to travel through TennCare initially, prior to distribution to the MCOs, the delay would make it very difficult for us to take action in a timely manner. Our current pharmacy program experience has demonstrated that web-based access to real-time pharmacy data is critical to effectively managing the pharmacy benefit.

2. In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.

The access to "real time" pharmacy data is imperative to proper management of the pharmacy benefit for the Medicaid population.

The pharmacy data is needed to perform case management/disease state management activities, drug utilization studies, quality improvement activities, and feedback to prescribers regarding the compliance of their prescribed treatment plan.

The Managed Care Organization (MCO) pharmacist must be able to access the current prescription therapy; this would include those medications filled and also those rejected. The prescriptions rejected are especially important to monitor those enrollees who are "drug seekers."

The information system must also have the ability for the MCO pharmacist to query the pharmacy information in order to perform drug utilization studies as noted in question 1.

If this data is not available, the case management activities are severely limited; the identification of "drug seeking" enrollees would not occur; and the over- and under-utilization of mental health medications (as an example) could not be monitored.

C. Long-Term Care Services

1. Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.

Centene is a medical managed care organization, and our core competency is coordinating care for various Medicaid populations. As part of our standard operations, we interact with a wide variety of agencies and organizations, including, but not limited to: state and local agencies, long-term care providers (such as nursing homes or skilled nursing facilities), housing authorities, educational systems, early childhood intervention agencies, departments of aging and disability services, court systems, child protective services, youth commissions, criminal justice systems, juvenile probation systems, etc. We understand that each population has unique needs. To that end, we excel at adapting our system of care to meet the specific needs of the population being served.

Centene recognizes that timely coordination of appropriate community-based Long-Term Care (LTC) services is critical in order to prevent, delay or reduce the progression of chronic conditions and the need for institutionalization. Centene places a high priority on meeting LTC needs, as well as meeting medical/behavioral health needs. We believe that all enrollees who receive on-going LTC services should be assigned to a Care Coordinator. The following processes are part of Centene's proposed model for LTC. It is important to note that Centene currently performs all of the processes described below, although not for LTC populations. We welcome the opportunity to deploy this model in Tennessee, as we believe that it represents a best practice approach to Long-Term Care.

Centene also recommends that if enrollees are to continue to be enrolled in their MCO while receiving LTC, this benefit should not be carved out of the MCO contract. Typically, it is in an enrollee's best interest to stay in his/her home for as long as possible. We recognize the key role that home and community based services play in allowing an enrollee to continue to reside at home. If we are not able to contract with these types of providers, it limits our ability to work collaboratively with them to maximize an enrollee's full health potential. Similarly, once an enrollee is admitted to a nursing facility, if the MCO is contracted with the nursing facility, the MCO is better positioned to work with the nursing facility's staff to coordinate care and discharge planning.

Centene's LTC Model

Initial Assessment. Once Centene receives a new enrollee enrollment file from the State, NurseWise, Centene's 24/7 nurse triage service, will attempt to conduct welcome calls for all new enrollees. During the New Enrollee Welcome Call, NurseWise assists each enrollee to complete a short Health Risk Screening Assessment (HRSA) to identify potential service needs. The HRSA includes questions about diagnoses, medications, hospital and emergency room use, activities of daily living, pain management, mental health conditions and use of medical equipment and supplies. Enrollees identified as needing LTC services and those already receiving services will receive an in-home assessment from a home health agency nurse within 72 hours for urgent needs and 14 days for routine needs. Care Coordinators will authorize services for emergency needs immediately, and an in-home assessment would be conducted within 24 hours. The nurse would assess the enrollee's functioning and determine the extent to which the enrollee requires assistance with activities of daily living (ADLs). If functioning is impaired and the enrollee needs ADL assistance, the nurse will facilitate locating appropriate resources for the enrollee. The nurse will forward all assessment information to the Long Term Care Team for review and assignment to a Care Coordination team for care plan development.

Transition Planning. For enrollees already receiving LTC services at the time they enroll, Care Coordinators will develop and implement a transition plan within 30 days of receiving the enrollee's enrollment package. The plan ensures that newly-enrolled enrollees experience no service disruptions, and that relationships with existing providers are maintained. The Care Coordinator authorizes the types and amounts of services in the existing care plan. If medical equipment or supplies were ordered prior to the enrollee's enrollment with

Centene, the Care Coordinator will follow up with the provider to ensure that the equipment or supplies are received without delay.

Authorization of Services. Centene will ensure timely delivery of LTC services by requiring Care Coordinators to authorize LTC services within specific timeframes. For emergency needs (defined as no available caregiver and unmet need for personal care that must be met within 24 hours), Care Coordinators will immediately authorize services and follow up with an assessment within 24 hours. For urgent needs (defined as a pending loss of caregiver for a personal care need that cannot go unmet for 24 hours), Care Coordinators will authorize services within 72 hours of assessment. For routine needs (defined as a personal care need that cannot be met adequately on an ongoing basis by family or other community supports), Care Coordinators will authorize services within 14 days of assessment. Even though these services are authorized by the plan, a file for all authorizations can be provided to the State to pay LTC providers contracted with the State and not with the MCO.

Coordination with the Primary Care Provider (PCP). The enrollee's PCP (or specialist acting as PCP), in conjunction with the Care Coordinator, is the central point of integration for the enrollee's health and LTC services. Care Coordinators work cooperatively and pro-actively with PCPs, regardless of network participation status, to ensure integration of all non-capitated, and non-Covered Services. The Care Coordinator consults with the PCP during care plan development and discharge planning; sends care plans to the PCP, so that a copy can be maintained in the enrollee's medical record; facilitates coordination, so that LTC providers obtain any required physician orders from the enrollee's PCP; and facilitates coordination between the PCP and behavioral health (BH) Providers. PCP contracts require PCPs to coordinate all services for enrollees requiring LTC. The PCP will provide overall clinical direction, whereas the Care Coordinator will authorize acute, skilled and LTC services according to the PCP's orders. Provider Relations Representatives educate network PCPs about the availability and role of Care Coordination, emphasizing the importance of working as a team with the Care Coordinator to integrate care. Education about Care Coordination also routinely occurs as Care Coordinators outreach to PCPs to coordinate the enrollee's care.

Providing Care Coordination. Care Coordination is a critical component in helping enrollees maintain the highest level of functioning possible, for as long as possible, in their homes and communities. The Care Coordinator is responsible for working with the enrollee/representative, family, PCP or treating physician, and other Providers to develop and implement a comprehensive care plan that addresses the enrollee's entire range of medical, BH, LTC and other needs. The Care Coordinator will actively facilitate the sharing of medical, treatment and planning information among the enrollee's primary, preventive, acute, specialty, BH and LTC providers. The responsibility for coordinating care encompasses network and non-network providers, Covered, Non-capitated and non-covered services, and community resources. The plan requires the Care Coordinator to maintain a single, centralized record for each assigned enrollee that includes all enrollee contacts, assessments and authorizations. This record reflects Covered, Non-capitated, non-covered and community agency services provided in order to create a holistic picture of all the enrollee's needs.

Centene provides Care Coordination in a manner that recognizes the varied needs and desires of enrollees. Enrollees who do not desire Care Coordination and whose LTC needs are episodic, rather than ongoing, can contact staff at any time a need arises and receive authorizations for LTC services within the same timeframes as those previously outlined. Enrollees with multiple chronic or complex conditions, including serious and persistent mental illness, or who have a chronic illness or functional limitation that puts them at risk for institutionalization, would receive ongoing comprehensive Care Coordination. Centene takes an integrated approach to Care Coordination, combining registered nurses (RNs), social workers and behavioral health clinicians to ensure a holistic approach to meeting the wide range of each enrollee's needs.

Discharge Planning. The plan's onsite concurrent review nurses will notify the Care Coordinator within 24 hours of an enrollee being admitted to the hospital. The Care Coordinator, as the enrollee's primary point of contact with the plan, schedules needed assessments and will work with the enrollee, family, attending physician, discharge planner, PCP and other relevant providers to coordinate discharge planning. The Care Coordinator ensures that hospital staff involved in discharge planning are aware of discharge planning arrangements and that such arrangements include LTC services, if appropriate.

Nursing Facility Entry and Discharge. Enrollees entering and recently discharged from a nursing facility will be assigned to a Care Coordinator for as long as their condition requires. The Care Coordinator will ensure

that an assessment is completed within 30 days of an enrollee entering a facility, to determine the enrollee's ability to transition back to the community. If the enrollee is not able to do so, the Care Coordinator will ensure that another assessment is completed within 60 days after facility entry, to determine if the enrollee's condition or circumstances have changed sufficiently to allow transition. If either assessment indicates that the enrollee can leave the facility, the Care Coordinator will work with the enrollee, family and providers to develop and implement a comprehensive care plan that includes necessary community LTC and transition assistance services.

2. What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?

Incentives for plans to maintain community based services might include:

- Health plans should be provided with financial incentives, in order to encourage them to perform assessments on enrollees 30 days after the enrollee has been admitted to an LTC facility, in order to assess the feasibility of the enrollee receiving services within his/her home. If the assessment concludes that home-based services are not feasible at that time, then the State should require that another assessment be performed 60 days after admission to an LTC facility.
- Health plans should be required to develop performance indicators that would include the number of enrollees entering institutional care settings versus the number entering community-based services, as measured on a yearly basis. Performance incentives could be established for those plans that demonstrate an increased use of community based services.

D. EPSDT Incentives

1. Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive programs to increase participation in EPSDT please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.

Centene realizes that mailings and telephone outreach alone are not sufficient strategies for reaching our target population. To that end, we have established a grassroots member outreach program, called CONNECTIONS, which is recognized in other states as a unique best practice. CONNECTIONS representatives are locally-based and hired from within the communities we serve. Representatives receive intensive training on such topics as health plan benefits, cultural competency, education and outreach techniques, etc. CONNECTIONS representatives meet with enrollees one-on-one in familiar settings, such as their homes or their providers' offices. Some of the Centene-owned health plans in other states employ CONNECTIONS representatives who have been Medicaid recipients at one time, and have a first-hand understanding of the challenges that enrollees face.

In Wisconsin, the Centene-owned health plan offers educational materials in Hmong and employs several Hmong-speaking individuals as CONNECTIONS representatives and Member Services Representatives. Likewise, in Texas, the Centene-owned health plan employs Spanish-speaking CONNECTIONS representatives, called *Promotoras.*

Following is a description of Centene's overall outreach and educational approach to EPSDT services:

Outreach and Informing Process. Centene health plans provide extensive education and outreach to ensure that all eligible enrollees understand the importance and availability of age-appropriate, comprehensive EPSDT services. Centene health plans have developed a comprehensive list of strategies that have achieved documented success in encouraging enrollees to schedule and keep EPSDT appointments. For example, 2003 Consumer Assessment of Health Plan Survey (CAHPS) results for Centene's Texas plan indicates that 82% of enrollees received reminders for check ups and shots. Centene outreach and informing processes include: targeted mailings (such as the New Member Packet, various reminders, newsletters, etc.); posted and distributed information (such as that available on our Websites and distributed at community events); telephonic interaction (including Welcome calls and outreach calls to non-

compliant enrollees); and face-to-face interaction (which takes place at health fairs and community events, as well as during personal visits by CONNECTIONS representatives.

Targeted Mailings. Within ten days of enrollment, the plan sends each new enrollee a New Member Packet, which includes a welcome letter asking the enrollee to schedule an initial health-screening visit within 90 days of enrollment, EPSDT reminder magnets, and a Member Handbook. The Member Handbook explains the importance of preventive care; the role of the PCP; the periodicity schedule; details about services; how to access EPSDT services; and how to get help accessing services. Annually, enrollees receive a Member Newsletter, which contains EPSDT education articles. We also send a Birthday Card to enrollees age birth to 21 during their birthday months, reminding them of the need to get a check up and offering help with appointment scheduling. EPSDT reminder postcards are sent to non-compliant enrollees and those due for EPSDT during the upcoming month.

Posted and Distributed Information. We provide information on our Website; in enrollee newsletters; at health fairs; and at community events (such as Family Reunions).

Telephone Outreach. NurseWise, Centene's 24/7 nurse triage and crisis line service, conducts Welcome Calls for each new enrollee within 30 days of enrollment to review the information in the Member Handbook; encourage the enrollee to schedule the initial health-screening visit; and offer help with scheduling and arranging transportation. Centene health plans use McKesson's CareEnhance Clinical Management Software (CCMS), an integrated information system that allows documentation and retrieval of episodes of an enrollee's care, regardless of source, and that provides automated reminders, so that Case Managers never miss important follow-up dates. Centene's phone system plays recorded reminder messages to enrollees while they are on hold, discussing the importance of getting EPSDT exams, lead screens and immunizations.

Face-to-Face Outreach. As previously mentioned, CONNECTIONS representatives conduct face-to-face visits to provide intensive education and assistance in enrollees' homes or in locations such as the Federally Qualified Health Centers (FQHCs); public county health departments; churches, community centers, and other venues frequented by enrollees with EPSDT-eligible children, such as recreational leagues sponsored by the Boys and Girls Clubs, YMCA, and after school programs. Other face-to-face opportunities that have been used successfully by Centene plans include monthly "Diaper Days," which include distribution of diapers, baby wipes, and EPSDT appointment scheduling at FQHCs, local public health departments and high-volume PCP offices, during which CONNECTIONS representatives distribute nominal non-cash incentives, such as "Cold Kits" and providers conduct numerous EPSDT screenings in a single day.

Educating Pregnant Enrollees. Our OB Case Managers (CMs) educate pregnant enrollees about the availability and importance of EPSDT services, including an exam for newborns within 24 hours of birth. After delivery, an OB CM contacts the new mom to confirm that the child was seen by a pediatrician for an exam and to stress the importance of ongoing preventive care. Centene health plans generate reports (see below) from claims data, indicating whether a claim was received for the EPSDT visit within seven days of delivery. If not, the EPSDT Coordinator conduct follow-up, as described below.

Ensuring Compliance with Periodicity. From Centene's experience with Medicaid and SCHIP enrollees in various states, we have determined that ensuring compliance with periodicity requires significant, multifaceted efforts. To implement and ensure effectiveness of our multiple compliance strategies, Centene typically hires a full-time EPSDT Coordinator, who has primary responsibility for coordinating all EPSDT efforts. Each month, the EPSDT Coordinator contacts non-compliant enrollees' parents/guardians to educate them about the periodicity schedule, depth and breadth of services and the importance of preventive care. The EPSDT Coordinator determines why the enrollee is non-compliant and implements strategies to address these reasons, such as arranging transportation to appointments. When the EPSDT Coordinator helps a non-compliant enrollee schedule an appointment, the EPSDT Coordinator contacts the PCP within one week of the scheduled date, to confirm that the appointment was kept. If not, the EPSDT Coordinator follow up with the enrollee for additional assistance via phone, or through a home visit from a CONNECTIONS representative. In addition, the EPSDT Coordinator is responsible for coordinating all EPSDT outreach events, including Health Check Days, and consults regularly with the Consumer Advisory Committees in each region, for feedback on outreach and increasing effectiveness.

Monitoring. Centene health plans monitor the outreach and the informing process, and assess how well enrollees understand EPSDT information by regularly reviewing enrollee grievances, provider complaints,

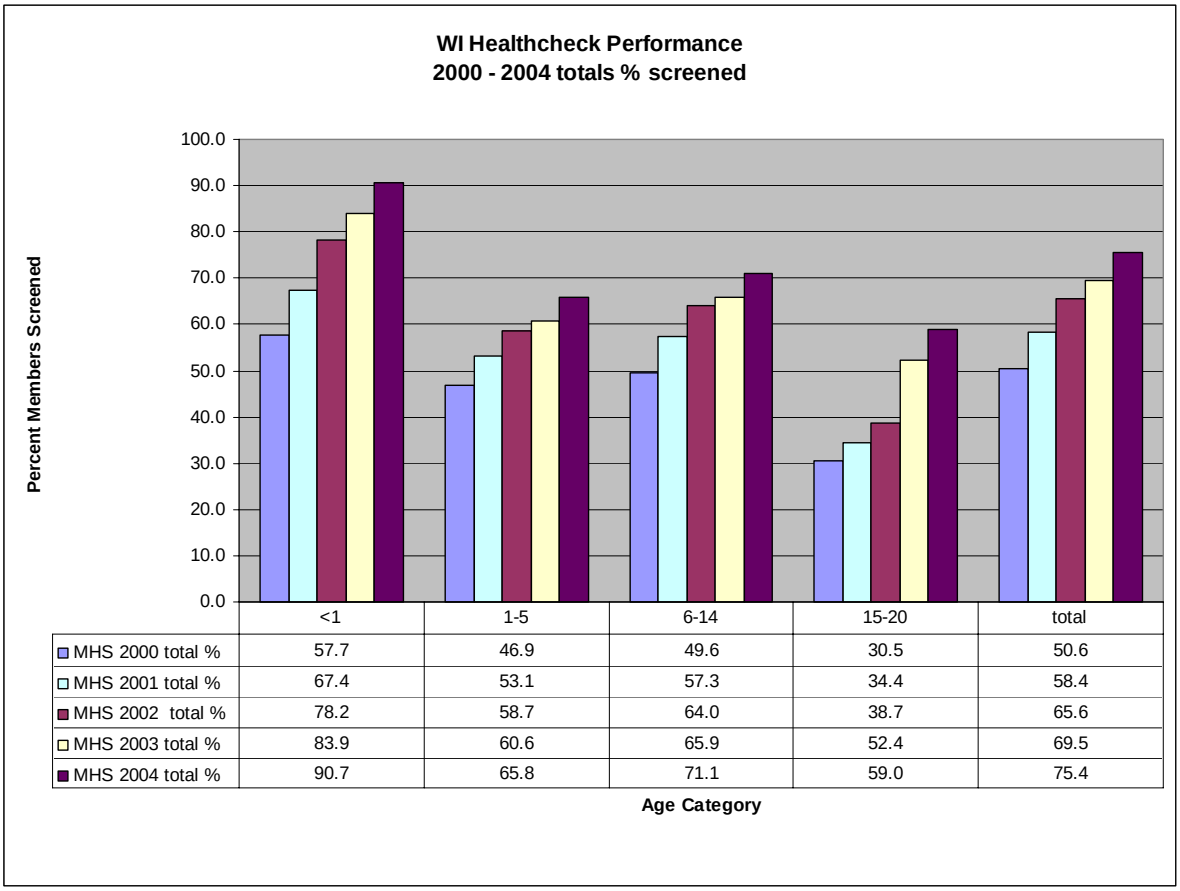
Consumer Advisory Committee input, satisfaction surveys, and EPSDT rate trends. Centene health plans monitor claims and enrollee data to identify enrollees who do not access EPSDT services within the first 120 days of enrollment, are non-compliant with periodicity, or are due for an EPSDT visit during the upcoming month. The Manager of Health Economics generates a monthly EPSDT statistics report using McKesson's Care Enhanced Resource Management Software (CRMS). The report is used to notify providers of assigned non-compliant enrollees, and to identify enrollees requiring reminders and outreach (see below for detail on follow-up). The Quality Improvement (QI) Department conducts medical record reviews, to ensure that PCPs provide all age-appropriate, state-required elements during EPSDT visits. Annually, QI Department nurses audit a statistically valid random sample of high volume PCPs, reviewing provider documentation to verify that all required elements are present.

Coordination with PCPs. Centene realizes that effective coordination between EPSDT Coordinators and PCPs is critical to a successful EPSDT program. The EPSDT Coordinator is responsible for ensuring that each network PCP receives a monthly list of non-compliant patients and a copy of all reminder materials sent to their patients, to facilitate the PCPs' own outreach and scheduling efforts. The EPSDT Coordinator contacts PCPs to confirm that noncompliant enrollees kept scheduled appointments and provide follow-up to encourage and assist with rescheduling. Centene health plans educate providers about periodicity, EPSDT requirements, and the help we can provide enrollees and providers, through provider orientation and group trainings, the Provider Handbook, the Website, annual provider newsletters, recredentialing and other site visits, and whenever a provider calls with questions or concerns. The Medical Directors of Centene's health plans meet with high-performing providers to recognize their efforts and to identify best practices that can be shared with other providers through the Website, newsletters or special mailings. Medical Directors also meet with low-performing providers to identify ways to improve outreach or other practices. Centene's health plans also typically offer quality bonus payments for providers who meet EPSDT performance goals, as developed by our Physician Compensation Committees, which are composed of network providers. For example, in Wisconsin, we have implemented a program that is based on feedback received from the Physician Compensation Committee, and that enables providers to periodically receive monetary incentives based on the number of EPSDT exams that they perform. For some provider groups, this has resulted in significant bonus opportunities.

Ensuring Provider Compliance. Each Centene health plan has a Manager of Health Economics, who generates a monthly EPSDT statistics report, to identify each provider's assigned, noncompliant EPSDT-eligible children. Identified providers are educated regarding required elements, targeted for other education and partnering efforts to increase compliance, and re-evaluated in six months. If partnering efforts remain unsuccessful, the provider is subject to corrective action (see below).

Experience. Centene health plans have successfully increased EPSDT compliance rates using education and outreach strategies. For example, Centene's Indiana plan, MHS-IN, exceeded the State's 2003 minimum targets for primary care access for 12-24 month olds and 26 month-6 year olds, and was just under the target for 7-11 year olds. MHS-IN also exceeded State targets for two common combinations of immunizations. The plan is currently implementing a new quality bonus strategy to boost performance further, paying provider bonuses for improvement in HEDIS outcomes for EPSDT. Centene's Wisconsin plan, MHS-WI, has in place a collaborative, multi-disciplinary, interdepartmental approach, led by a full time EPSDT Coordinator, which illustrates best practice outreach and informing practices. CONNECTIONS representatives participate in numerous health fairs and other community-based events, to contact and educate enrollees about required exams, immunizations, lead screening and other preventive services. MHS-WI collaborates with Milwaukee's Health Department, Public School system, and WIC projects, to conduct enrollee outreach at community locations, such as schools, school-based clinics, and high-volume WIC sites. CONNECTIONS representatives help enrollees select PCPs and make appointments, and provide benefit education and counseling. In 2001, MHS-WI implemented an initiative to measure and increase compliance with the State periodicity schedule. MHS-WI worked with the Milwaukee Health Department, community agencies, key provider offices and the public school system to offer screenings in schools and centralized locations. MHS-WI also sends reminder postcards. This process enabled MHS-WI to achieve statistically significant improvement in the EPSDT screening rate from January 2003 through December 2004 in all age cohorts. The most significant increase was in the <1 year old age cohort; however, substantive improvements were noted for all ages, as shown in the following table.

Table #7 – MHS Wisconsin – EPSDT (Health Check) Performance 2002-2004



	<1	1-5	6-14	15-20	total
MHS 2000 total %	57.7	46.9	49.6	30.5	50.6
MHS 2001 total %	67.4	53.1	57.3	34.4	58.4
MHS 2002 total %	78.2	58.7	64.0	38.7	65.6
MHS 2003 total %	83.9	60.6	65.9	52.4	69.5
MHS 2004 total %	90.7	65.8	71.1	59.0	75.4

E. Utilization Management/Medical Management (UM/MM)

1. Please describe any experience you have managing care in a state with benefit limits, including both "hard" and "soft" limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ for "soft" limits and the general criteria that would be utilized to evaluate requests.

Centene is experienced in providing utilization management/medical management services for Medicaid enrollees in physical health plans in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas, and Wisconsin. In each of these states, Centene uses a combined approach of enrollee education, prior authorization, and intensive case management to manage enrollee benefits.

Our educational approach aims to encourage enrollee responsibility and prudent health care behavior practices and to become a trusted resource for the enrollee when he/she isn't sure what to do. One program we have implemented to encourage enrollees to prudently use the health care system is the Emergency Department Diversion (EDD) program, which is based on early identification of enrollees who frequent the ED. Staff educate enrollees on how to access their PCPs; identify and eliminate roadblocks to primary care; arrange transportation; and appropriately use the ED. We also educate enrollees regarding the importance of following prescription instructions. Centene's multi-lingual Nurse triage services are available on a 24/7 basis in all of the markets where our health plans operate. Our triage nurses provide home health care instruction for minor conditions, help enrollees make appointments with their providers, and direct enrollees to the ED when appropriate, per the evidence-based triage guidelines in use.

As is our practice, any benefit limitation exclusion would fall under a prior authorization system. Centene health plans have extensive experience in implementing prior authorization processes as a mechanism to authorize services that may be in excess of benefit limits or that qualify for coverage if medically necessary. Centene health plans recognize hard benefit limitations and determine which, if any, soft limitations are best managed through an authorization process verses system benefit control.

As in most states, full exclusions, such as organ transplants, which are excluded from coverage under Tennessee's contract, are strictly applied. However, our staff case manages those enrollees until such time as they qualify for return to Fee For Service (FFS) Medicaid. Close consideration is also given to enrollees who present with another primary payer. In such cases, the plan ensures that enrollees with other primary coverage do not have primary carrier responsibility applied to plan limits.

Centene's health plan approach is focused on proactive recognition and management of all plan benefits by providing active case management services and focused assistance through our extensive provider networks. Our care management programs do not rely on catastrophic or benefit exhaustion to identify and manage enrollees at high risk. Our robust reporting capabilities enable us to identify enrollees early in the care process and to ensure that services are delivered at the appropriate level.

In support of our efforts to manage limits, Centene utilizes national evidence based medical decision support criteria. Our UM goal is to facilitate the provision of medically necessary covered services that are appropriate for the enrollee's condition, provided in the appropriate setting, and meet professionally recognized standards of care. We utilize evidenced-based UM guidelines that were developed by and/or based on recognized national criteria that reflect currently accepted medical and behavioral health care practices. These criteria are used as a guide, while considering special circumstances that may require deviation, such as disability, acute condition, or life-threatening illness. Board certified consultants may also be used to determine medical necessity of a particular benefit. Our staff is skilled at identifying and moving the enrollee to the lowest and most appropriate level of care within medical parameters. If a review results in a reduction of service or service level, only our Vice President of Medical Affairs (VPMA) is authorized to issue a notice of action.

In instances when the case management plan has exhausted benefit limitations, the case manager and VPMA would work with the PCP, enrollee and enrollee's family, to successfully complete the episode of care. The VPMA would authorize any extension of services beyond the state limits, and the case manager would ensure that the enrollee received all medically necessary services to complete a plan of care. In some instances, the plan might choose to remove the soft limits entirely, in deference to our care management programs. Our specially trained Member Services staff monitor the claims, to ensure that the enrollee is held harmless from any authorized services.

2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of "soft" limits.

Centene is skilled at providing services that are medically necessary and delivered in the most cost-effective setting. While our Medical Management and claims systems can administer benefit limitations, our extensive care management experience is not grounded in administration of services based on limitations.

Our experience shows that limitations to medically necessary services have the potential to become quality of care issues. Decisions regarding care provision must be based on the individual conditions presented by the enrollee at the time of the service performance. Centene utilizes experienced physician leadership, consistent application of medical decision support criteria, and aggressive case management, to appropriately coordinate available medical services.

Benefit limitations such as those proposed in the RFI, can lead providers and enrollees in the wrong direction when accessing care services. Providers may be hesitant to treat or continue treatment when they are aware of the enrollee's benefit limitations, even with preauthorization. The provider may feel that it necessary to utilize higher dollar services, in an attempt to maximize benefit limitations. With the proposed benefit limits, the enrollee may be reluctant to seek access to appropriate preventative care services or may stretch the time between visits, in order not to exceed the benefit limitations. Some enrollees, such as those on dialysis, may not be aware of the short list of encounter types and products that will not count toward the benefit limit, and therefore, they might skip medical services that are aimed at preventing complications. Foregoing preventative care services or misunderstanding that some encounters may not count against the benefit limits could cause

an increase in the severity of the current condition and could result in a medical crisis, which is always more costly to manage. With benefit limitations, it is our experience that enrollees tend to use less effective and more costly delivery mechanisms, such as the Emergency Department, in order to receive care. If enrollees regularly access care at Emergency Rooms, instead of with their PCPs, this will result in fragmenting their care.

Complex cases are also likely to be impacted by these proposed benefit limits. For instance, an enrollee with multiple medical problems requires close management by a multidisciplinary team of medical providers. Enrollees of this complexity require monthly visits to their PCPs and specialist providers, in order to monitor progress, to control their diseases, and to prevent acute exacerbations. Limiting access to Physician Outpatient/Community Health Clinic/Other Clinic Services to only 12 visits per calendar year could inadvertently result in utilization of higher cost services, such as Emergency Room or Inpatient Services, to manage the episode of care. Centene has proven successful experience in providing high quality cost effective management of these cases without imposed benefit limits.

Centene feels that inpatient hospital services can best be managed through admission and concurrent review screenings that evaluate medical necessity and appropriate level of care. Centene health plans rely on an extensive network of alternate care facilities and services, such as skilled nursing care, rehabilitation facilities, home health care, etc., to enhance our ability to provide appropriate services.

The following scenarios provide case scenarios that demonstrate our concerns with benefit limits:

Service & Proposed Limit	***Scenario***
Inpatient Hospital Services: Proposed limit- 20 days per calendar year for non-institutionalized TennCare Medicaid adults aged 21 and older.	Toni, - female, age 37 years old. Diagnosis: Crohn's Disease. It is early November and Toni has been in the hospital several times already this year due to her chronic problems with Crohn's disease (diarrhea, dehydration, constipation and bowel obstruction). In four hospital episodes, Toni has already used her allotted 20 inpatient days. Toni has been complaining of abdominal pains for several days. Her provider has attempted to manage the abdominal pain since she has refused inpatient services, because she knows she has exhausted the benefit limit. This morning Toni awoke with vomiting and severe abdominal pains. She called her PCP, because she had already used all of her hospital days, and the doctor directed her to the Emergency Room. Emergency Room testing confirmed acute intestinal wall rupture, and she was admitted to the hospital for emergent resection of the bowel and treatment of sepsis, requiring a 20 day admission. In this scenario, the quality of care was compromised because of the patient's reluctance to be admitted until the intestinal wall rupture and subsequent sepsis occurred.
Physician Outpatient/Community Health Clinic/Other Clinic Services: Proposed Limit – 12 visits per calendar year for non-institutionalized adults aged 21 and older	Henrietta - female, age 47 years old. Diagnosis: Uncontrolled Hypertension, Endometriosis, and history of Seizure Disorder. Henrietta 's blood pressure has been uncontrolled and has necessitated ten visits to her PCP this year. She also sees her neurologist every three months for her seizure disorder and requires visits to her gynecologist for treatment of her endometriosis. Henrietta decided that in order to stay in compliance with her 12 visit limit, she will only see her neurologist. She has had several seizures, but refused to

Service & Proposed Limit	***Scenario***
	mention them to her PCP, since she does not want to incur the cost of a visit to the neurologist. As a result of her decision, Henrietta is found in the hallway to her apartment having a seizure. 911 is called and during the Emergency Room visit to control the seizure, it is identified that her blood pressure is also uncontrolled, necessitating a 5 day stay in the hospital. Because of the benefit limit, Henrietta was hospitalized instead of simply seeing her physician. This resulted in poor quality of care. This problem could have been avoided simply by additional office visits.
Laboratory and Radiology Services: Proposed Limit – 8 per year	George - male, age 59 years old. Diagnosis: Obesity and Hypertension. To appropriately manage these diagnoses, George requires monthly visits to his PCP office for monitoring and medication management. George takes Lasix for his hypertension. Lately, George has had difficulty with potassium levels due to the Lasix. His doctor has recommended monthly lab work to monitor his potassium levels. Last week, George noticed swelling in his hands and feet. This week he developed a cough. The doctor recommended a chest x ray; however, George decided to forego this recommendation, knowing that he had already used his 8 lab/radiology benefits for the year. Two days later, George suffered respiratory arrest at home and was transported to the hospital via EMS and admitted to the ICU on a vent due to Congestive Heart Failure (CHF). Because of the benefit limit, a hospitalization was necessary, instead of the less expensive lab and x-rays. This also resulted in danger to the enrollee's life.

Centene strongly recommends that careful consideration be given to the various limitations presented with this RFI. An example is the 'no quantitative limit' on organ transplants and donor procurement. We believe that this benefit could cause confusion regarding the inpatient hospital services limit of 20 days per calendar year, as well as outpatient service, laboratory and radiology service, and physician service limits. Centene health plans would rather manage the risk of catastrophic cases through a multi-disciplinary approach that involves our Case Management staff, the attending physician, the hospital, the enrollee, and the enrollee's family and support system. We believe that such an approach enables the enrollee and his/her team to develop a service/treatment plan that provides the most appropriate medically necessary services at the most appropriate level of care. Centene is confident of our ability to manage these cases cost-effectively without imposed benefit limits. We utilize the following proven methods of benefit management:

Our multidisciplinary care management team is comprised of experienced nurses, social workers, physicians, pharmacists, and program coordinators. We use our dynamic information systems to proactively identify enrollees with multiple chronic conditions, multiple medications, high emergency room and/or inpatient utilization, high cost outpatient utilization, etc. for screening for Case Management programs. Enrollees in Case Management are contacted regularly, to monitor status and to provide individualized education and assistance as needed. Enrollees are informed of the availability of our 24 hr nurse triage line, which may be accessed at any time of day or night, for questions regarding medical care. The nurses on our nurse triage line are trained to assist enrollees with identifying the most appropriate level of care.

Centene realizes that we cannot prevent all inpatient admissions, and that inevitably, some enrollees will require hospitalization. At such a time, our experienced Case Management staff conducts early and ongoing reviews of all inpatient admissions, which allow for rapid feedback regarding inappropriate admissions and appropriate length of stay, and which acts as a sentinel for future admissions. These ongoing reviews provide an opportunity to build strong relationships with the hospital Case Managers. A regular internal concurrent review or 'rounds' process is conducted on all "at risk" cases, to ensure that each patient is being managed

without delays. Peer collaboration occurs in order to determine effective ways to intervene as necessary to improve quality or to reduce unnecessary costs.

Our talented Case Management team is also involved in discharge planning at or before the inpatient admission, in order to remove barriers and to arrange for any services that may be required for a successful timely discharge. A network designed to include alternative care sites, levels of care, agencies and providers to match requirements to the provision of care is an essential component of our successful discharge planning program.

In summary, Centene prefers the challenge of a full risk capitation environment without the use of benefit limits to manage care. Such limits often confuse enrollees and providers, and drive up the cost of more expensive, but unlimited services, such as Emergency Room. This has the potential to undermine the quality of care received by enrollees, and to adversely affect the continuity of care received through their PCPs. Centene's health plans have successful track records in managing these limitations in states where we are contractually required to do so.

F. Disease Management

Physical Health

1. Do you have a formal disease management program? If yes, where is it currently being used, e.g., which State Medicaid programs?

All of Centene's health plans have disease management programs in place. Our disease management programs currently serve Medicaid, SCHIP and SSI enrollees in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas and Wisconsin. In addition, various types of disease management functions are also provided by Centene's specialty companies, Cenpatico Behavioral Health, LLC (CBH), NurseWise LP (24/7 nurse triage and crisis line services), and AirLogix, the recognized industry leader specializing in respiratory disease management

Again, if yes, on which conditions does your program focus today?

Centene health plans currently focus disease management activities on asthma, diabetes mellitus, and high-risk pregnancy, based on their prevalence in the health plans' populations.

2. Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

Disease management functions are performed within our health plans and/or in conjunction with the Centene specialty organizations mentioned above. The degree to which these subsidiaries are utilized varies among the various health plans and disease management programs.

3. Please describe your disease management approach, and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also describe what additional health conditions you might recommended for targeted intervention techniques (e.g., obesity, pain management)?

Disease Management is an integrated component of the Medical Management function at Centene health plans. Centene's disease management programs are based on the premise that improving the health of enrollees with chronic conditions requires empowering them to actively manage their own health care. Effective self-management is a critical factor in the control of chronic conditions, but fostering self-management requires more than a lecture about habits or a postcard appointment reminder. It requires helping the enrollee to understand the central role he/she plays in his/her own care, and encouraging him/her

to take responsibility for managing his/her condition. The level of intervention received by each member is based on the severity of the member's illness and the complexity of co-morbid diseases and/or social factors. Informed and motivated enrollees, working in partnership with providers who are familiar with and supported in the provision of evidence-based care, achieve better health outcomes and enjoy a higher quality of life than those who do not play an active role in directing their own care. Centene's disease management programs are staffed with case managers who are registered nurses, and who are assisted by program coordinators who possess 2-3 years managed care or physician's office experience and a thorough knowledge of customer service, utilization review or claims processing practices in a managed care environment.

Centene's approach to managing within the context of benefits limits is the same for our disease management program as it is for our utilization management program as described above in Section E.

To date in 2005, Centene's health plans have the following number of enrollees being case managed through our three primary disease management programs:

Case Mgmt. Category	IN	KS	MO	NJ	OH	TX	WI
Asthma	4,441	641	405	1,069	6,301	4,390	815
High Risk Pregnancy	6,519	5,785	2,096	1,455	1,258	3,398	1,503
Diabetes	585	10	39	847	122	494	76

Goals

The goals for all of Centene's disease management efforts are to identify all enrollees in the applicable CMO programs who have the disease being managed, including those at high risk for complications and high resource utilization, in order to teach enrollees to effectively self-manage their condition; to ensure that providers treat these conditions according to accepted clinical practice guidelines; and to reduce inpatient hospital admissions and emergency room visits that result from these conditions. For the asthma program, an additional goal is to ensure enrollee compliance with prescribed medications. The driving philosophy for all programs is that informed, supported providers and pro-active enrollee self-management are the key factors in achieving improved quality of life for enrollees with chronic conditions.

Identification of Potential Participants

For each of the specified groups, Centene uses utilization, claims, pharmacy and assessment information, as well as provider, enrollee and other referrals, to identify enrollees in need of disease management and to stratify them by risk level. Utilization Management (UM) Departments receive a weekly Trigger Diagnosis report and a monthly Emergency Department report; both generated from claims data that indicate ICD9 codes for treatment. Centene's health plans also receive information from concurrent review nurses who are on-site each day at network hospitals to monitor all hospitalized enrollees. Any enrollee receiving in-patient or emergency room treatment with an applicable primary diagnosis is identified as a potential disease management program participant. The UM Department reviews Vendor Drug Program pharmacy data to identify potential participants, for example, by looking for enrollees receiving B-2 agonist medications and long-term controller medications, such as inhaled corticosteroids; medications related to diabetes; and ACE inhibitors or ARBs. Centene also generates a monthly report from claims data indicating potential enrollees for disease management, such as those receiving diabetic supplies and devices. Potential participants are also identified through provider, enrollee, family/caregiver and other referrals, and through health risk assessments.

Program Components and Outreach

Outreach varies by risk level, and includes home visits to hard-to-reach enrollees and those with no phone service. Each program includes enrollee and provider education and outreach, along with high-risk case management.

Enrollee Education. Centene believes that when enrollees have the information they need to make informed decisions regarding their own health care, they have the strongest potential of changing modifiable health risks and improving their overall health status. Centene's overarching philosophy to disease/case management centers on allowing enrollees to be accountable for their own care. Centene's enrollee educational materials

are designed to encourage enrollees to take responsibility for their own care, seek care from their PCP, and contact our nurse call line when they have questions or need advice.

- **Motivating Responsible and Prudent Health Care Behaviors and Practices:** At the core, encouraging responsible use of health care requires motivating enrollees and families to take actions that they perceive to be in their own interest. Acting in our own interest comes naturally to most individuals; however, enrollees may lack the knowledge or the resources they need to effectively access health care services. Centene's goal is to become a trusted source of healthcare information for enrollees, so that if they aren't sure what to do, the first thing that comes to mind is: "Call my health plan and ask." Once Centene achieves face-to-face, telephonic, or written word contact with enrollees or their parents/guardians, we educate them about why and how they should take specific actions that will benefit their health and overall wellbeing. For example, in March 2005, Member Services at Centene's Indiana plan received a call from a distressed woman who said, "I called you because I didn't know who else to call and I was afraid I might hurt my child." The Member Services Representative looked in the CCMS system, noted that the enrollee was in Case Management and "warm transferred" the enrollee to her Case Manager, who determined that the enrollee was exhibiting signs of post-partum depression. The Case Manager talked with the enrollee, and together, they agreed that the enrollee would discuss her situation with her PCP. She also transferred the enrollee to a stress management clinic that partners with the plan. Later that day, the Case Manager followed up and confirmed with the PCP that the enrollee had received a referral to see a BH provider.
- **Health Promotion Materials:** Centene health plans' health promotion materials are designed with support from Centene's Corporate Communications department, in an easy-to-understand manner (5th-grade reading level or below), with graphic elements that make them appealing to enrollees. Materials are culturally relevant to enrollees, and can be produced in multiple languages. Some materials address all enrollees' general health and well-being (for example, regarding nutrition and preventive care) and others target high-risk groups of enrollees (for example, enrollees with asthma) to explain symptoms of their conditions, self-help measures (such as how certain home environment practices can reduce asthma symptoms), and how to access appropriate care. Centene also provides information to all enrollees about disease management services in our Member Handbooks.

Provider Education. Centene utilizes an approach consistent with provider performance improvement models published by the National Committee for Quality Assurance (NCQA) and the Centers for Health Care Strategies (CHCS) in working with providers to improve adherence to clinical practice guidelines. Specifically, Centene utilizes peer comparisons of meaningful disease specific performance indicators, and provides practice management systems that are easy to implement and use.

In general, Centene takes the following steps to improve adherence to the clinical practice guidelines:

- **Continuous measurement and feedback.** In order to achieve goals for provider compliance with practice guidelines, Centene continuously measures adherence and provides meaningful and timely feedback to providers. Measurement includes such activities as profiling for eligible providers and analyzing provider-specific HEDIS measures.
- **Practice Management Educational Mailings and Toolkits.** CHCS uses a tool kit approach in packaging condition-specific information for use in provider offices. For example, in Texas, Centene's subsidiary health plan, as part of the CMS Diabetes Quality Improvement Project, introduced an Outpatient Rapid Assessment Tool designed to systematically prompt discussion between the provider and enrollee about the need for preventive services. Centene often includes the provision of such tools as a vehicle through which to improve adherence to guidelines. In addition, we develop and distribute quarterly educational mailings that address specific prescribing or treatment activities, to help foster changes in practice management. These materials are developed internally and are based on nationally recognized evidence-based guidelines.
- **CMEs/CEUs related to clinical practice guidelines.** Centene may offer continuing education programs related to practice guidelines relevant to the population for providers and licensed staff in their offices. Large provider multi-specialty groups in each Service Area are targeted first. Centene tailors the best practices developed by our health plans such as collaborating with community-based organizations to develop staff training that reflects local concerns and populations.

- **Physician-to-Physician Telephonic Consultation.** When providers are found to be performing substantially below their peers or identified by other key indicators or patterns of performance as needing educational intervention, Centene's Medical Director may outreach to that provider to conduct one-on-one consultation.

Care Management. High-risk enrollees are offered the opportunity to receive complex care management through a multidisciplinary team model that brings together a registered nurse (RN) for clinical expertise, a social worker (LCSW or MSW) for psychosocial issues, and a Program Coordinator for administrative support to the Team. During the first phone or in-home contact from the CM, the enrollee is informed of his/her right to opt out of the program with no loss of access to covered services. The Care Management/Care Coordination Team ensures that enrollees understand their condition and how to manage it appropriately; assesses and addresses compliance with prescribed care and instructions; identifies and addresses barriers to self-management; arranges for environmental and other assessments as needed; works with the PCP to develop, implement and monitor physician-driven care plans that addresses enrollees' ranges of needs in a holistic and effective way; obtains specialist referrals; obtains or replaces equipment/supplies (such as nebulizers and spacers for asthma and glucose monitors/strips for diabetes); coordinates and collaborates with the family/caregiver and with covered, non-covered and non-capitated services; conducts outreach to community resources, such as schools, local chronic condition coalitions, advocacy and support groups, and other organizations that provide assistance that these enrollees may need; helps enrollees during problems with acute exacerbations; coordinates discharge planning and care plan revision to prevent readmissions; provides appointment reminders; monitors enrollees' care, treatment, self-management and health status (with frequency determined by the individual enrollee's needs) to determine if care plan goals and objectives are being met; and submits written progress notes to the PCP regarding the enrollee's care, adherence to the care plan and health status.

Evaluation

Centene evaluates each program annually through the Quality Assessment and Performance Improvement (QAPI) process, to determine clinical and financial impact and whether/how the programs should be modified to increase effectiveness. Outcome measures include utilization and PMPM costs for emergency room and inpatient hospitalization with a primary diagnosis of asthma, diabetes, CHF, CAD, COPD or pregnancy (non-delivery related); number of outpatient visits per asthma episode; HEDIS Use of Appropriate Medications for People with Asthma measure; HEDIS Comprehensive Diabetes Care Measure; HEDIS Use of Spirometry Testing in the Assessment and Diagnosis of COPD measure; ACE inhibitor and ARB prescription rates; and mortality rates associated with CHF, COPD or CAD. Centene distributes clinical evaluation results to providers to keep them informed of the programs' effectiveness and highlight areas in which care provided deviates from recommended guidelines.

Centene's philosophy to Disease Management is:

We manage people, not diseases

Recommendations for Additional Programs

Centene's experience in coordinating care for Medicaid recipients, particularly for the aged, blind and disabled population, has demonstrated that many enrollees are dealing with multiple co-morbid diseases, which can result in challenges in administering traditional disease management programs. Based on this experience, we recommend not implementing additional programs that focus on individual disease states. Rather, we believe that the best approach to disease management is to develop a medical management structure that allows Care Coordinators to look holistically at each enrollee and to devise a strategy that best addresses each enrollee's unmet needs.

For example, Mary O. has both diabetes and congestive heart failure. In a traditional DM environment, Mary would receive educational mailings or reminders about the appropriate treatment for both of her diseases; however, she would not necessarily receive assistance with removing potential barriers to care. Moreover, since she has co-morbid conditions (as do over 50% of the ABD population), then she could become overwhelmed with the volume of educational materials and redundant interventions that she receives.

If Mary is enrolled in Centene's health plan, then, based on her multiple co-morbid conditions, the Centene Care Coordinator would proactively contact her. The Care Coordinator talks to Mary to identify unmet medical, behavioral or social needs. Mary says that she has not scheduled appointments for her routine testing, because her car broke down and she has been unable to afford the repairs. The Care Coordinator explains to

Mary that her MCO will pay for her transportation to her appointments, educates her about how the benefit works, and encourages her to make the appointments as soon as possible. When the Care Coordinator follows up with Mary a month later, she has already seen her primary care physician and has scheduled an appointment with an ophthalmologist for her diabetic retinal eye exam for the following week.

Behavioral Health

In addition, the following behavioral health conditions are targeted for care management interventions:

- ***Schizophrenia***
- ***Bipolar disorder***
- ***Major depression***
- ***Co-occuring mental illness/substance abuse***

4. Does your care management program include behavioral health conditions? If yes, where is it currently being used?

The Care Management program utilized by Cenpatico Behavioral Health, Centene's behavioral health subsidiary company, includes Care Management interventions for all of the behavioral health conditions listed above. These Care Management interventions are currently being used for enrollees in Centene's health plans in Indiana, Kansas, Missouri, Ohio, Texas, and Wisconsin.

CBH's Care Management program is designed to meet national best practice standards, such as URAC and NCQA. In 2004, CBH achieved URAC Health Plan Accreditation.

5. Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

Behavioral health care management is performed by wholly-owned subsidiaries of Centene. We do not subcontract with any outside vendors for the provision of behavioral health care management.

6. Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.

The CBH care management model is highly individualized, rather than a one-size-fits-all approach. CBH is also committed to demonstrating treatment effectiveness and to efficient use of health care resources. The alignment of these two concepts comes through a "clinical pathways" approach to care management. Each enrollee's individualized care plan includes decision points where progress is evaluated. If a client shows no improvement on agreed-upon goals at specific points in time, the planning process resumes, and the enrollee again is consulted about goals, milestones, and the use of various available treatment modalities.

The CBH innovative care coordination model does not prescribe specific treatments for specific disorders. Historically, BHOs have recognized the therapeutic equivalence of different treatment modalities, but have interpreted this finding to mean that the least expensive treatment should be applied first. Because there is clear evidence that not all treatments will work for all clients, this approach is likely to produce costly treatment failures. CBH does not seek to impose particular treatments or limit enrollees' options. Instead, the CBH care coordination model stresses providing enrollees with available, research-based knowledge and guidance, allowing enrollees to choose what resources they believe will assist them most, and helping Enrollees locate and connect with those resources. Key to this effort is CBH's experience partnering with existing systems of care, which allows us to take advantage of current community strengths and treatment options, while at the same time working collaboratively to develop needed resources that may not exist at the local level.

G. Capitation Model

Under the TennCare reformed managed care model the State will be returning to capitated managed care.

1. Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.

Centene operates in a prospective payment environment. The following approaches best ensure success for the states to whom we provide services, as well as the individuals enrolled in our health plans:

- **Keeping the entire member whole:** We recommend that all of the money connected with service delivery (e.g., pharmacy, transportation, dental, vision, etc.) be built into the premium. As previously mentioned, we believe that carving out services, such as pharmacy, behavioral health, and/or SSI, can potentially undermine the efficiency and soundness of approach to physical health services, and can also have a detrimental impact on overall patient care. We believe that quality of care and financial efficiency are best accomplished when pharmacy, behavioral health and other services are integrated into the overall care management system. Specifically, the integration of behavioral health within the managed care model is critical to ensuring effective coordination of care and to achieving healthy outcomes.
- **Lock-in:** We recommend a lock-in approach for at least 12 months. Centene has found a direct correlation between the time an individual is enrolled in a plan, the individual's satisfaction with his/her plan, and his/her clinical outcome. Accordingly, we have concluded that a 12-month lock-in provides the best opportunity for improved clinical outcomes and sustained cost savings.

2. Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.

A full risk capitation environment would positively affect Centene's decision to participate. Centene views a full risk capitation environment as one in which the MCO is paid a monthly flat fee for assigned enrollees, and the MCO is financially responsible for all medical and administrative costs, including inpatient and outpatient services. Under such an arrangement, there would not be any benefit limits on items such as number of doctor visits, inpatient days, etc.; rather, the MCO would assume full responsibility for utilization management and patient and provider education, thereby limiting the state's financial exposure.

Centene would be less interested in a limited risk capitation environment, that is, one in which the benefit package contains significant limitations that minimize Centene's ability to administer effective preventative care in conjunction with exercising prudent utilization management techniques. Centene would not be interested in pursuing an ASO arrangement in which only the administrative fees are at risk.

3. The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:

a. State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)

b. If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)

c. If the State adopted "soft" benefit limits, aggregate risk sharing (e.g., the state reimburses X% of costs in excess of X% of capitation payments)

d. Other

Centene would prefer a full risk capitated approach for all enrollees.

4. Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?

Centene prefers to operate at membership levels greater than 100,000.

5. Preferred approach to Rate Setting

Centene recognizes that TennCare and CMS require actuarial sound rates in order for the program to be successful. Centene's preference would be that TennCare have an actuarial firm set actuarial sound rate ranges (minimum and maximum rates that will be considered) by rate payment cell. These rate ranges would be released along with the Request for Proposal (RFP) and a Data Book that consists of cost models for the most recent three years. The Data Book should include historical claims and utilization by category of service for each rate payment cell, as well as detailed analysis of the adjustment included in the development of the rate ranges. The adjustments should include items such as trend, benefit changes, administration load, risk selection load, reinsurance, and managed care impact. Information contained in the Data Book would provide bidders with the necessary historical data and required information to develop competitive bid rates. Each bidder would develop its own actuarial certified rates within the set rate range.

Centene has worked with states that issued competitive bids without an actuarial sound stated range, as well as with states where actuarial sound rates were set by the state's actuarial firm. We feel that the above method represents the best of both methods, and protects both the state and the bidders. Whatever method is determined by TennCare, a Data Book would need to be issued, in order to assist bidders either with bidding rates or with determining the adequacy of the predetermined rates.

Non-Maternity Rates

For non-maternity rates, Centene suggests that TennCare employ a design that is similar to that of other markets where we operate. Typically, rates are split by product (TANF, SCHIP, and SSI) and by age and gender, as illustrated in the table below:

Table #8: Suggested Rate Cells

TANF Rate Cells	*SCHIP Rate Cells*	*SSI Rate Cells*
Male & Female - <1 year old	Male & Female - <1 year old	Male <30
Male & Female 1 - 5	Male & Female 1 - 5	Female <30
Male & Female 6 - 13	Male & Female 6 - 13	Male 30 - 39
Male 14 - 20	Male 14 - 20	Female 30 - 39
Female 14 - 20	Female 14 - 20	Male 40 - 64
Male 21 - 44		Female 40 - 64
Female 21 - 44		Male 65+
Male 45+		Female 65+
Female 45+		

We recommend that there be two sets of SSI rates that follow this design: one for those who are eligible for Medicare, and one for those that aren't eligible for Medicare.

SSI rates are normally risk adjusted using the Chronic Disease and Payment System (CDPS). Risk adjusting the SSI rates allows for a fairer distribution of revenue among the MCOs, based on the severity of each MCO's SSI population. The total revenue paid out by the State remains the same.

Maternity Rates

Centene proposes that the maternity costs be carved out from the rates. Under such a model, the State would provide an additional payment for each delivery incurred by an enrollee of an MCO.

Centene proposes using the following method to identifying a delivery:

- Within the first 60 days after the birth of a newborn, a Medicaid number will be assigned to that newborn. TennCare will review the records to identify the mother's Medicaid number and to what PCP, if any, the mother is assigned.
- Next, TennCare will review the medical records of the mother to ensure that this is a legitimate delivery. In other words, if there has been another delivery within the last 8.5 months since the time of the newborn assignment of a Medicaid number, then there is an error.

This method will reduce the time that it takes from the date of delivery until the delivery payment is made to the MCOs, because the State will not need to rely on the proper submission of encounter data.

H. Data and Systems Capability

Critical to the success of the program is the availability of robust, timely data, including encounter data, for use by the State and MCOs to manage and monitor the program. The State is very interested in MCO capacity to obtain and provide data and reports to the State, and capacity to use data for ongoing program monitoring and quality assurance.

Information Systems Overview

Centene views effective Data Management as a core strategic capability for effective managed care. Centene recognizes the significance of structured, expertly-operated and well-maintained Management Information Systems (MIS). Technology investment in this area has been an executive management priority.

We view the following capabilities as important for any Data Management Strategy:

- Enterprise Data Model
- Operation Data Store
- Reporting Tools
- Middleware Capabilities
- Data Storage Infrastructure
- Comprehensive Data Management
- Technology for Data Accessibility

1. Enterprise Data Model

Centene recognizes the architecture for an enterprise data model should incorporate a logical method that meets critical business components. The Centene enterprise data model is a cross-functionally-consistent view of the managed care business and key stakeholders. The data model is supported with an Oracle 9i relational database management system to store provider, beneficiary and claims transactions. The model includes relationships enforced by foreign keys and is optimized for high-volumes. The Centene data model schema defines the data and their relationships applied to our organization.

2. Operational Data Store

Centene utilizes the Operational Data Store as the foundation to support our data reporting strategy. It is critical that the data management architecture is separate from transaction processing to optimize performance and flexibility.

- The Operational Data Store on Oracle 10g is a relational database and tuned for high-speed retrieval of information.
- The Operational Data Store supports Operations in reporting, ad hoc data analysis, and is refreshed daily.
- Security layers by user login.
- Oracle SQL is based on the ANSI SQL-99 standard.

3. Reporting Tools

Centene utilizes the Business Objects Crystal Enterprise XI software package to offer reporting, query and analysis, and data integration. This robust reporting tool offers world class functionality to easily extract data and produce reports.

- Enables external data access via a Secured Web Portal.
- Allow business users to easily create queries and create ad-hoc reports without having to understand complex database languages and structures.
- The users can easily configure and generate reports in various formats such as Microsoft Excel, Microsoft Word, and Adobe Acrobat PDF.

The reports can be scheduled with pre-determined parameters, reporting formats, and then published to a document management system.

4. Middleware Software Capabilities

Centene's middleware architecture is the 'backbone' of system integration and maintains data integrity and minimizes latency across the enterprise. Data is updated and validated through a set of common business rules and processes.

5. Data Storage Infrastructure

Centene has incorporated two critical application servers for the data storage management process.

- MS/SQL database (for Windows servers)
- Oracle database (for HP-UX servers).

These two industry leading database architectures provide a highly reliable and scalable environment to meet our company's data processing requirements.

- The databases are accessible through the Storage Area Network (SAN).
- SAN provides a fault tolerant access to the data storage unit (HP XP 1024 Storage Array).

The SAN infrastructure was designed using the latest technology available from Cisco Systems with growth and scalability in mind.

- The Storage Array currently provides 25 Terabytes of RAID protected storage and, most importantly, can quickly scale to 129 Terabytes of usable data storage.

6. Comprehensive Data Management

Centene's multi-line business model provides an integrated framework for viewing enrollee utilization and clinical data across multiple areas of care. Medical, Pharmacy, Behavioral Health and Disease Management data are available to form a single view of enrollee reporting.

This concept gives Centene clinical staff to gain immediate insight into patterns and trends. A wide range of detailed and summary views of data reveals opportunities for improving quality for managing care.

7. Technology for Data Accessibility

Centene views Data Access as core design principle and utilizes a web portal technology to provide access outside of the enterprise. Business needs such as production access to verify eligibility and provider inquiries, query capability against the Operational Data Store are available as well.

1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.

Encounter Data Overview

Centene recognizes the importance of encounter processing and reporting to comply with standards set forth by each State and/or fiscal agency. Centene has dedicated personnel, expertise, and the hardware to ensure performance is at an optimal level to efficiently handle the State's system requirements. Centene currently

exchanges encounter data successfully with the State agencies responsible for MCO/MBHO oversight in Arizona, Indiana, Kansas, Missouri, New Jersey, Ohio, Texas, and Wisconsin. These are examples where encounter submission processes currently take place.

We view the following capabilities as important for any encounter processing methodology:

- Encounter Processing Methodology
- Meeting Data Submission Performance Standards to the State

1. Encounter Processing Methodology

Centene can meet the needs of varying submissions of the same data. In one instance, Centene provides encounter data to two different agencies, using different file layout standards and different transmission methods and standards. Centene provides encounter data in strict adherence to each state's standards for file format, file size, submission frequency, submission method, and any other requirement that the state and/or fiscal agency implements. Files are transmitted via a secure protocol stipulated by the state and/or fiscal agency.

Centene's encounter reporting process makes use of the data produced via the claims submission process and validation steps through Centene-developed programs to build encounter files for submission. This process uses the state-specific standards to guide programming to include the needed data elements, needed file formatting and transmission mode.

The development of encounter files results in a series of reports to ensure data integrity, timeliness and external completeness.

- Exception Reports result from internal edit checks on claims data as it is transformed to encounter submissions. These reports are reviewed by the Health Plan.
- Detailed Encounter Logs of submitted files are maintained.
- Resubmission reports allow track and trending of the rate of encounters found to be in error by the State, as well as the outcome of resubmission of encounters.

2. Meeting Data Submission Performance Standards to the State

Centene monitors performance of regulatory submissions, including the formatting of data and file layout, based upon a review of standards and proposed submissions, performance feedback on files that have been submitted, and reports on performance in other areas such as the timeliness of file submission against State standards

Data validation occurs using the following methods:

- **Timeliness:** State deliverables are generated via an Operation's Schedule. Scripts generate emails automatically, notifying appropriate staff of the file/report generation and its location on their secured server. Jobs are reviewed to ensure that they ran completely.
- **Change processes:** A formalized change process maintains a check list of sign off levels that must occur before any programming or configuration is modified. Appropriate role based sign off occurs to ensure that coding changes are tested and reviewed at multiple levels.
- **Completeness:** Reconciling reports are generated at each control point when data is being uploaded, extracted or modified. Summary and detail level reporting occurs in order to allow for strict validation if needed.
- **Accuracy/Validity:** In order to ensure validity throughout the system, appropriate staff assess all State and/or fiscal agency data requirements prior to building the detailed data requirements and editing procedures. An example of this would be encounter data requirements and the editing that occurs on the state's system. Requirements on the state's side that must be met when submitting encounters should be reflected in the design of our upfront editing criteria.

2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.

Provider Network Overview

Centene recognizes that the stability of the provider network is a key factor in the success of the program. The stability of the provider organization is significantly impacted by client volume and accurate and timely claims payment.

We view the following components as critical for maintaining a provider network:

- Monitor Provider Network Performance
- Measure Provider Network Performance
- Evaluate Provider Network Performance

1. Monitor Provider Network Performance

Centene utilizes multiple tools to gather provider client volume and claims payment data. Centene loads all provider claims and quality data into McKesson's CareEnhance Resource Management (CRMS) application. CRMS is an integrated suite of software products that creates a sophisticated database merging clinical and financial data. CRMS is a flexible product that allows Centene to monitor a variety of provider's client volume and claims payment patterns. CRMS also has the flexibility to adopt specific monitoring standards and produce reports based on those standards.

2. Measure Provider Network Performance

The CareEnhance Resource Management (CRMS) application provides Centene with an integrated clinical and financial view of care delivery to measure and improve performance. By utilizing the set of tools that CRMS offers, Centene can successfully integrate claims, Enrollee, and provider data into a single repository by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information. The result is quick access to providers' client volume and claims payment patterns.

The CareEnhance Financial Profiler gives Centene quick access to core managed-care measures. This application tracks financial and clinical information over time so that Centene can develop targeted interventions and quantify the impact they have on quality outcomes. High-level reports are available directly to desktop for managers. CRMS also has sophisticated, built-in reporting tool for analysts.

3. Evaluate Provider Network Performance

The CareEnhance Patterns Profiler, which is also a CRMS tool, allows Centene staff to gain immediate insight into the provider practice patterns and underlying claims histories. A wide range of detailed and summary views of practice pattern data reveals opportunities for improving quality based on practice guidelines.

In addition to the data produced from CRMS, Centene tracks claims payment data on a monthly basis through reports to ensure that claims payment standards are met. The data from these various sources are integrated and reviewed monthly by the Centene management team. If there is a significant variation in the data on a monthly basis Centene meets with the provider agency to review the data. As a qualitative measure, Centene meets with providers to review claims volume and claims payment data, to ensure the ongoing stability of the provider network and to make improvements in performance when necessary.

I. Net Worth and Restricted Deposit Requirements

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

No, Centene does not view this as a deterrent. All Centene health plans have different levels of statutory and net worth requirements.

J. Implementation Timeframe

The State's anticipated timeframe for the procurement and implementation of the TennCare Middle Region reform calls for bid procurement in January, with selection of MCOs in April and service delivery beginning in October. MCOs and any subcontractors accepting risk (e.g., BHOs) will have to be appropriately licensed in Tennessee prior to implementation.

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

No. Centene is interested in exploring the possibility of whether or not to participate in the program, regardless of the implementation timeframe.

Centene's Implementation Team encompasses over 70 years of collective experience in health care implementations, and is experienced at mobilizing our corporate resources to ensure successful implementations.

Our recent implementation experience includes the following:

- In 2004, Centene successfully launched MCO services for TANF and SCHIP members at Buckeye Community Health Plan in Ohio, and in 2005, we expanded these services into a new region.
- In September 2004, we expanded our service offering in Texas, resulting in an additional 90,000 SCHIP lives.
- In January 2005, we successfully launched MCO services for TANF and SCHIP members at FirstGuard Health Plan in Kansas and FirstGuard Health Plan, Inc. in Missouri
- In 2005, we implemented behavioral health services in three new markets: for SCHIP recipients in Kansas; for TANF, SCHIP and low-income uninsured populations in Arizona; and for TANF and SCHIP recipients in Western Missouri.
- In July, 2005, Centene was awarded a contract to provide MCO services for TANF and SCHIP members in Georgia. Within three months of contract award, Centene's Georgia-based subsidiary health plan had successfully contracted with more than 1,100 providers. The health plan anticipates going live in July 2006 with a complete network that fulfills the State's Geo Access standards.

The implementation timeframes for these deployments mentioned above varied from as few as three weeks to as long as 16 weeks. Our extensive experience at deploying new operations attests to our ability to successfully deploy in Tennessee, regardless of the implementation timeframe determined by the State.

2. Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?

In Centene's experience, most states usually announce contact award one or two months following the submission date of the response to the Request for Proposal (RFP).

Centene has implemented numerous state contracts for both physical and behavioral health services. Our average implementation timeframe is 4-6 months. We believe that the longer timeframe of six months is preferable, as it enables the most effective identification of information system requirements as well as operational requirements (such as hiring and training of new employees, robust provider contracting, etc.). In addition, the longer timeframe allows for the development of appropriate pre-implementation meetings between Centene and the State, for the purpose of coordinating regulatory and contract requirements.

Auto Assignment. Aggressive implementation timeliness require expedient communications among all parties regarding enrollee selection and auto assignments. Adopting an approach to equally divide enrollees who do not select a plan would benefit the MCOs as well as TennCare. This would enable both successful MCOs to reach economies of scale, thereby equally dividing TennCare's financial risk. This approach would also enable TennCare to administer the enrollee assignment process internally, if so desired, rather than

contracting with an enrollment broker. Centene's experience with other states' Medicaid agencies has been that it is difficult for them to effectively manage the implementation of a managed care program with multiple MCOs concurrently with implementation of an enrollment broker contract.